The Public Health Nurse

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CONVENTION NUMBER

Sophie C. Nelson, R.N.

The New President of the National Organization for Public Health Nursing

The PUBLIC HEALTH NURSE

Official Organ of The National Organization for Public Health Nursing, Inc.

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IMPRESSIONS OF THE CONVENTION

Milwaukee has set a precedent in biennial conventions which it will be difficult to duplicate! Never have nurses attending a biennial convention been so impressed by the apparent ease with which the crowd of 4,000 and more nurses was handled, by the skillful way in which meetings were managed and by the air of unhurried enjoyment which pervaded all the details of the program. The huge Auditorium provided ideal conditions for both large and small group meetings. For once, we literally met under one roof, and the use of amplifiers in the arena, where all joint sessions of the three national organizations were held, made the addresses a pleasure to listen to and not a strain.

Spacious lobbies proved a convenient greeting place as friends passed from one meeting to another, and a lunch room in the basement made impromptu luncheon parties a possibility. The special luncheons and dinners ran off like clock work, and the Schroeder Hotel which was headquarters for the three national organizations provided ample space and courteous service. To the veteran convention goer the exhibits in the basement seemed unusually valuable this year, perhaps because of their uncrowded arrangement and the leisure time provided to visit them between meetings.

Of particular advantage to the delegates were the rules governing all meetings. The doors were closed as the meeting was called to order, late comers were admitted only at the close of addresses and people allowed to leave only between papers. Observance of these courtesies not only added to the ease of the speaker but allowed the audience to give undivided attention to the subject presented.

The N.O.P.H.N. general program presented questions of community public health: the nurse's part in health administration, control of communicable disease including the tuberculosis and social hygiene program, industrial nursing, child health and mental hygiene. Round tables were arranged according to population groups, according to function, and specialty, and if the two-hour period proved insufficient time to allow for free discussion, it nevertheless did give opportunity for the presentation of public health nursing practices and left all of us desiring more time to talk about them.

The spiritual values of nursing presented by Glenn Frank, President of the University of Wisconsin, at the opening joint session, were balanced (in later sessions) by the consideration of financial values, the cost of medical care, the cost of nursing service, and the educational aspects of our whole professional program. Nor was entertainment omitted. A beautifully trained student chorus of almost a hundred voices was a delightful addition to the evening meetings, and the reception given by the Wisconsin nurses at the Eagles Club was a particularly happy opportunity for each person to greet the officers of the three national organizations.

Last, but by no means least, mention should be made of the board members' participation in the Convention. Nurses and friends of nursing have appreciated the importance of this group of lay workers, but the board and committee members who came to Milwaukee seemed to have an increased sense of responsibility, each for her own organization and for the general health progress of her own community which was an inspiration to everyone. They attended meetings indefatigably and had a real share in all phases of the public health nursing program. In fact, the keynote of the entire week's sessions emphasized the relationship of the nursing service to the broader health program; and the responsibility of the individual in making that relationship effective.

Helen S. Hartley

The non-official agency is best qualified to develop and prove the worth of new projects in the public health field. It is well qualified to discover the best technique and methods of procedure. After the value of new procedure has been demonstrated to the satisfaction of the non-official agency as well as to the official agency there remains the task of educating the general public to the need of such new or improved methods in public health work, and the creation of a demand for the official adoption of such procedure. When this function has been successfully accomplished the administration of proven procedures should be referred to official agencies, and the efforts of private agencies directed toward further experimental research and development.

The private agency must recognize the difference in standards and ideals that are attainable by public agencies which are limited by appropriations, public sentiment and are highly restricted by legislative enactments which frequently do not permit official agencies to proceed as far in administrative procedure as voluntary agencies. The official agency must constantly guard itself against the possibility of exceeding authority granted by legislative action. Harmonious relations between official and voluntary agencies can only exist when each is willing to work in harmonious relations with the ideals and restrictions of the other.

—From the address of Errol V. Brumbaugh, M.D., Deputy Health Commissioner, Health Department, Milwaukee.

Capable of pertinent analogy by public health nursing agencies offering affiliating courses to undergraduate students is Miss Rottsman's paper on "Affiliations for Nursing Schools from the Viewpoint of the Receiving Hospital," which appears in the *American Journal of Nursing* for July. We call particular attention to health requirements presented by the affiliating student and efficiency ratings. Other articles of interest to public health nurses in the July *Journal* are:

The Patient and the American Nurses' Association	Elnora Thomson, R.N.
Nursing Care of Cancer Patients	Anne A. Ferris, R.N.
Publicity Methods and Costs	Emma L. Collins, R.N.
Study of Hand Cultures	Leila I. Given, R.N.
Memorial to Miss Clayton	Annie W. Goodrich, R.N.
Learning Prevention First Hand	E. M. Jamieson, R.N.

Convention Reports

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

PARTIAL REPORT OF THE PRESIDENT, MRS. ANNE L. HANSEN*

IN the two years which have elapsed since we met in Louisville much has happened which, if time permitted, I would delight to discuss with you, but it seems desirable at this time to bring only the most outstanding events to your attention.

The death of our most efficient and esteemed Treasurer, Mr. Alexander White, was a keen loss to our Organization. For many years Mr. White added a deep sympathetic understanding of public health nursing to his duties as Treasurer, and this radiated to many of his own group.

Miss S. Lillian Clayton was an ex-officio member of our Board of Directors. The news of her sudden passing on May 2 of this year was a shock from which we have not yet rallied. Her clear thinking gave her an understanding of our problems which makes it impossible to attempt to estimate the contribution she made to the cause of public health nursing. We deeply mourn her loss.

The resignation of Miss Ada Carr as Editor of THE PUBLIC HEALTH NURSE, is an item which I report with mixed feelings. We are sad to lose Miss Carr officially and yet retain a great pride in what she has accomplished—a sincere thankfulness that the N.O.P.H.N. has been the beneficiary of so many years of glorious service. We put up a prayer that she may be spared to give us counsel for many years to come.

As previously stated in this meeting one of the happiest things I have to report is the appointment of Miss Katharine Tucker as Director of our Organization. Next to that comes our joy at having Mary Gardner, Honorary President, present with us in our Board meetings, ever ready to help and advise from that great store of knowledge which is so peculiarly hers.

Many of our Board meetings have been cheered by a visit from Miss Lillian Wald, our other Honorary President, and to Miss Wald we extend our sincere appreciation for her generosity in loaning the room at 99 Park Avenue for our Board meetings.

The Board was fortunate in securing Mr. Michael Davis for Treasurer. Mr. Davis has contributed most liberally of his time and energy to his appointed office and to consideration of the financial needs of our association, both as Treasurer and as Chairman of the Finance Committee. We are delighted that Mr. Raymond Clapp, Director of the Cleveland Community Fund, found it possible to accept a position on the Board of Directors left vacant by the death of Mr. White. We heartily welcome both Mr. Davis and Mr. Clapp to the field of public health nursing.

Our most grateful thanks are given to the many Committees and especially to the Chairmen for devoted service over the past two years. The reports are printed and I trust you will give them careful study.

One of the most significant studies made during the last two years (and perhaps in all the history of the N.O.P.H.N.) is that made under the leadership of a Special Committee, called the Committee on Policies and Program, with Mary S. Gardner as Chairman. In the life of an organization there comes a time when it is necessary to view thoughtfully and dispassionately the past and the present, to draw a new map for future activities. Your Board of Directors has gone through such a process on your behalf and now presents to you the result of its deliberations.

(Mrs. Hansen then outlined the main points presented in the report of this committee, points already printed in the pages of this magazine, see June, 1929.)

* N.O.P.H.N. Business Session, Biennial Convention, Milwaukee, Wis., June 9, 1930.

This, my Presidential Swan Song, is one of pride and gratitude. Gratitude for the many courtesies from all of you and for the privilege of serving you in conjunction with a wonderful Board of Directors, together with Katharine Tucker and her outstanding staff; pride in this great National Organization with its limitless service for humanity.

REPORT OF THE GENERAL DIRECTOR, BIENNIAL PERIOD, 1928–1930

KATHARINE TUCKER

In any organization it is well to review periodically its progress, trends, and accomplishments and to consider its problems and possible next steps. With the N.O.P.H.N. this review naturally takes place every two years. You know from the President's address and past reports in the magazine* that during this period there has been a study of the place, function, and program of the organization which has brought certain reaffirmation as to the essential need for it and a clarification and direction as to its desirable emphases.

At this time I will briefly recapitulate these conclusions as a basis for the report of the activities during this period and for possible future development. The primary concern of the N.O.P.H.N. is to assist public health nursing organizations and public health nurses to take their place in all phases of health work so that they may contribute most effectively and adequately. The implications of this are that the N.O.P.H.N. functions through, with, and for all allied agencies, national, state and local, and especially its own membership, corporate and individual. Also, through the work of its committees and through statistical studies it continues to gather and evaluate facts on the present status of public health nursing, on the basis of which next steps may be considered and newer standards thereby may be developed.

RELATIONSHIP TO OTHER NATIONAL AGENCIES

Definite progress has been made in developing relations with other national groups. Of primary importance has been a clearer definition of the division of responsibility with the other two nursing organizations. Just how far or fast this can go in concretely shaping programs remains to be seen. Already the recognition of differences in function has greatly facilitated working relations. There has been a gratifying tendency on the part of the other national health bodies to use the N.O.P.H.N. as consultant in phases of their programs that touch on public health nursing or even more definitely to regard it as their public health nursing department. With both the National Tuberculosis Association and the American Social Hygiene Association, joint projects have been worked out, administered by the N.O.P.H.N. on the basis of a shared financial responsibility. The American Public Health Association through its Committee on Administrative Practice turns to this organization in matters of policy of administration and in field studies where public health nursing is concerned. The closest reciprocal coöperative relation exists with the public health nurses on the staffs of the American Child Health Association and the National Society for the Prevention of Blindness. The foregoing are illustrations of very definitely developed ways of joint planning and operation. With a far larger group of national agencies the same spirit of interchange, so as to get and give the benefit of each other's special experience, obtains.

SPECIAL PROJECTS—INDUSTRIAL NURSING AND SOCIAL HYGIENE

The two joint projects, one with the National Tuberculosis Association and one with the American Social Hygiene Association deserve special mention. For some time tuberculosis groups have recognized the bearing of indus-

* See THE PUBLIC HEALTH NURSE, June, 1929, and December, 1929.

trial health work on the prevention of tuberculosis. At the same time the potentialities of the use of the nurse in the industrial health program have been realized by the N.O.P.H.N. These combined interests are back of the industrial nursing project to which a large part of the time of one of the N.O.P.H.N. staff members is now assigned. The object of this project is to assist in defining the place of the nurse in the industrial health program, what should be her preparation so she may be able to meet these possibilities, and through all available channels to further ways of providing such preparation and of making effective use of industrial nursing services.

Similarly in the social hygiene project it is a question of studying the place of the public health nurse, the preparation that she needs, and assisting public health nursing agencies to incorporate this important phase of health work in their own programs. A specially prepared nurse has been added to the staff to carry on this activity. For each of these projects there are joint committees representing the national agencies concerned and specialists in each field.

RELATION TO STATE DEPARTMENTS OF HEALTH

The N.O.P.H.N. is equally anxious to work more closely with state departments of health and their public health nursing staffs. Definite steps in this direction have been taken and as time goes on we believe this relationship will be strengthened and new ways open up for a mutually productive use of each other's services.

RELATION TO MEMBERS

Promoting the sound development of public health nursing through the relationship between the N.O.P.H.N. and its membership, corporate and individual—potential and actual—continues to be its predominating concern and this relationship constitutes its greatest strength and opportunity for service. The N.O.P.H.N. represents the accumulated experience of years and the present experience and practice of those directly engaged in public health nursing. Problems of administration, of the content of various phases of public health nursing programs, of details of procedure, and of the relationship of public health nursing to other groups are constantly puzzling all those who are considering and analyzing their own work. No one can answer these questions simply by contemplating them alone in relation to her own agency or her own community. No one sitting in the isolation of any one national office can answer them either—and herein lies the significance of the N.O.P.H.N.'s seeking closer contact with other national bodies and with the field. Locally and nationally we are thinking in terms of the whole health program. Public health nurses and public health nursing agencies by virtue of their equipment and direct contacts are placed in a strategic position to act as the medium through which a large part of this health program is made effective. It is important that the national body in its own development should point the way by acting as part of a greater whole, not attempting to think as an unrelated entity.

FIELD SERVICE

During the last two years the organization has increasingly emphasized field service. Twenty-eight states have been visited by members of the staff—we wish we could have made this 48. Unfortunately, there are both budgetary and time limitations. This is particularly to be regretted when we consider the west and far west which have so much to give and gain through closer contact. It is our plan to make these more distant groups a definite objective for the next biennial period. However, although we face frankly the fact that during these two years our field service has been limited to the north, south, east, and middle west, we are happy to record that within these states approximately 100 communities have been visited and direct contact made with more than three times that number of different public health nursing services. When one adds to this

many hundred more contacts through office interviews and correspondence with all the states in the Union, with representatives from all sorts, sizes, and conditions of agencies, the national aspect of the work becomes even more apparent and its opportunities and responsibilities even greater. It has stretched even beyond our own borders. Letters and very welcome visitors have brought international contacts, especially through the Montreal meeting of the International Council of Nurses.

During this same period 11 field studies of public health nursing organizations have been conducted in as many communities. There is increasing recognition of the value of such an appraisal of program, methods and accomplishments by an impartial body working with the local group.

STATISTICAL SERVICE

The statistical service both through consultation and advice as to local problems and through special statistical studies has a very direct value for the field. The following studies have been completed or begun in the last two years:

Annual salary studies.
Annual studies of students registering in post-graduate courses.
Study of negro nursing.
Study of nurses in commerce and industry.

In addition, Miss Tattershall has made 7 field visits to advise as to the record systems in certain agencies.

OTHER SERVICES AND ACTIVITIES

Other definite activities have continued to serve the membership and others.

Bibliographies have been called for and specially prepared or brought up to date by various members of the staff on the following subjects: industrial nursing, social hygiene, school nursing, general public health nursing, and supervision. There is evidence of an increasing desire on the part of those responsible for public health nursing to know more about publicity methods. Therefore, material has been assembled and contacts made with specialists in this field so the N.O.P.H.N. can more satisfactorily respond to this demand.

As the report on the vocational and placement service of the organization, now administered under the Joint Vocational Service will be given and published separately, it is not included in this report.

In any such kaleidoscopic review of services, it is impossible to picture all that has been included in the day-by-day work of the staff. This is particularly true as it relates to the advisory and consultation service given through office interviews and correspondence and the constant calls to serve as a central bureau of information in all that immediately or remotely relates to public health nursing. While there seems no way of adequately evaluating or reporting on such services they are some of the most time-consuming and most necessary. One comes to feel that the slogan is "When in doubt, ask the N.O.P.H.N."—whether the doubt has to do with a survey of the whole public health nursing field in regard to some particular problem or with answering a question as to some detail of administration.

An activity of special interest came from the Rosenwald Fund which asked the coöperation of the N.O.P.H.N. in conducting a study of the present status of negro nursing in public health nursing agencies. Part of the study was carried on through the statistical service but an equally important part involved the visiting of eight different localities including contact with a large representative group from which both facts and opinions were obtained. A description of the findings of this study will soon be published in the magazine. Another activity which has called upon the resources of the organization both in terms of staff time and the assembling of previously gathered material, has been the various committees of the White House Conference.

THE MAGAZINE

The magazine has continued as in the past to be the official publication of

the organization. From reports already printed the decision of the Ideal Magazine Committee, created to consider a combination of the *American Journal of Nursing* and THE PUBLIC HEALTH NURSE, is well known. After 4 years of study the committee came to the conclusion that 2 magazines were necessary to cover the needs of the professional fields. However, through a joint editorial council at headquarters a very much closer relationship has developed between these two journals resulting in less duplication of material and a real division of responsibility.

A special effort has been made in the last year to keep the members closely in touch with the activities of the staff and the considerations of the board through the section on the "Activities of the N.O.P.H.N." As with the rest of the organization, the magazine seeks to reflect both the needs and experience of the field. While we are still far from carrying a subscription list large enough to make the magazine self-supporting and we believe that many more would find it profitable to read the magazine, there has been a gratifying increase in subscriptions. We also feel that the combination subscription rate with the *American Journal* and the *Survey* has met with favor as a saving to the individual nurse.

Miss Carr's retirement as Editor January 1, 1930, has already been reported upon with deepest regret. It is impossible to measure all that she has given to the organization and public health nurses through this and other countries. Our affection and good wishes will always be hers. With the N.O.P.H.N.—its staff and members—will always remain her gifts of spirit, understanding and rare insight that will constantly illumine its progress. Passing from assistant editor to editor, Miss Deming has already justified the confidence felt in her, and we rejoice in our good fortune in her taking over this position.

SECTIONS

Through its sections the interest of certain special groups of its individual members is represented. One of the outstanding events in the history of the N.O.P.H.N. was the formation of the Board and Committee Members' Section at the Louisville Convention in 1928. No one realized how soon the dream of its possibilities was to come true. Through the generous renewal of the money previously contributed to the Financial Study Fund, it was possible to make the larger portion of it applicable to the activities of the Board and Committee Members' Section. A secretary for this section was added to the staff who is particularly equipped to serve this group so closely associated with the development of the whole public health nursing movement. Only second in importance to this achievement is the actual production of the long-awaited Board Members' Manual.

The Industrial Nursing Section had a most successful annual meeting at the same time and place as the 1929 Annual Meeting of the National Safety Council. There was excellent attendance and an unusually stimulating program. By adding all members of the Executive Committee of this section to the Joint Advisory Committee on the Industrial Nursing Project, every effort will be made to relate the interest of the section to the project activity. It is hoped that membership in this section will increase so that it may really serve industrial nurses throughout the country as their national body.

Similarly it is desired to have the School Nursing Section serve as the national medium for this particular group. Forty regional advisors representing school nursing in 35 states have been appointed. A study was made by Miss Beatrice Short in 1929 of the status of school nursing—its administration and operation—in 63 communities. From this factual material and through the advisors we can learn what now is being done. Wide variation is discovered in practice which indicates the desirability of having this nationally representative group continue to consider objectives and goals in school nursing service. In coöperation with

the Education Committee the section has outlined courses that might be given to school nurses in four successive summers, encouraging educational institutions to make these available. The response has been most satisfactory.

The Tuberculosis Nursing Section has state chairmen in 46 states who have been appointed to keep alive the interest and sense of responsibility of nurses in the tuberculosis program. This section will consider at this Biennial whether a section is the most effective method of attaining this goal or whether an advisory council with regional representatives might not prove more satisfactory.

FINANCES

The N.O.P.H.N. is supported from 3 sources: membership dues, individual and corporate; contributions; and payment for services rendered. During 1929 there was a very appreciable increase of individual members over 1928. Up to date in 1930 we are not keeping pace with 1929 figures. While the loss in this direction has serious financial implications, even more important is its relation to the whole philosophy back of the organization. Notation of the situation is made at this point simply as regards finances but its more far-reaching significance will be discussed later.

Definite progress is being made in corporate membership on the percentage plan. In May, 1925, this plan was first presented to our membership and at the close of the year 51 associations had voted to adopt the plan. At the close of the next year, 1926, 95 associations had adopted the percentage plan, and as a result our income was $7,800 more than had previously been secured from this source on the old basis of dues. At the beginning of 1928 we had 112 corporate members and in 1929, 157, with a total income from this source of approximately $17,000, an increase of approximately $10,000 over 1926. Eleven associations are paying the full 1 per cent. While this report is encouraging there is still plenty to be accomplished in furthering this type of membership on a full 1 per cent basis.

The financial stability of the organization is dependent primarily on income from these two membership sources just as both the direct and indirect services of the organization are related particularly to these two groups. Therefore, it is within the power of the membership to say to what extent the services will grow through an increase in the number of organizations on the percentage plan and the amount of the percentage paid, also in the number of public health nurses belonging as individual members.

Of course the business department and the staff are constantly engaged in promotional activities along these lines, but their success in great part rests upon a real sense of mutual responsibility within the agencies and nurses themselves.

The income from contributions remains practically as during the last Biennial period with most generous support from a few individuals.

Increasingly the sum for payment of services grows. It is but right that the larger, direct services in the field should be paid for by the agencies benefiting thereby with a definite credit of 25 per cent of their dues for those on the percentage plan.

The income from all these sources continues to meet the expenses with a sufficient surplus to maintain a reserve fund for emergencies. It is the avowed policy of board and staff to continue in this sound financial condition so that the expenses will at no time exceed the available funds. Therefore, the only way to increase the organization's activities is at the same time to increase its income.

COMMITTEES

As in the past the standing and special committees with widely representative membership have performed some of the most important functions of the organization. The following briefly summarizes their activities during the last Biennial period.

The *Finance Committee* — Mr. Michael M. Davis as Chairman—has

held 4 meetings. It has given the most careful consideration to matters relating to the budget—expense and income—of the N.O.P.H.N. It has also thoroughly reviewed the financial policies of the organization in consultation with specially qualified persons who have met with the Committee in an advisory capacity. The result is a consensus of opinion that membership dues, corporate and individual, must be increasingly the stabilizing factor in finances and there is hearty approval of the furtherance of the percentage plan.

The *Education Committee* — Miss Gertrude E. Hodgman as Chairman—has held 4 meetings of the Committee as a whole and 3 meetings of its smaller "Ad-Interim" subcommittee. Its activities have been the publishing and distribution of an outline of courses for school nurses; follow-up work, both in the field and through correspondence and interviews, of the special study on staff education and student affiliation with particular emphasis laid on staff educational programs for small groups; the assembling and publishing of material on scholarships, loans and leaves of absence. A loan folder has been prepared on efficiency report forms and a special study has been conducted in conjunction with a student group at Teachers College as to the desirable content of such forms. Considerable time has been given to questions relating to the preparation of negro nurses for work among their own group; and the preparation of industrial nurses for their particular opportunities is now engaging the attention of the Committee. During this period 7 post-graduate courses have been visited and as always the general and special problems of the courses are part of the work of the Committee.

The *Eligibility Committee* — Mrs. Theresa Kraker Guthrie as Chairman—has had 4 meetings. Its responsibility continues to be related to policies in regard to the credentials of applicants for membership and more especially the reviewing of problem cases.

The *Committee on Field Studies and Administrative Practice*—Miss Sophie C. Nelson as Chairman—has held 6 meetings. It serves in a dual capacity—as a Subcommittee on Nursing of the Committee on Administrative Practice of the American Public Health Association as well as a standing committee of the N.O.P.H.N. In these relationships it is concerned with outlining the objectives of the various phases of public health nursing programs and with the consideration of how these may best be administered; it also considers questions of policy and of methods relating to field studies of public health nursing services.

Publications Committee—Miss Elizabeth G. Fox as Chairman—has held 4 meetings. Questions of policy and general planning for the magazine have been considered. It participated in and acted favorably upon the recommendations of the Ideal Magazine Committee.

Records Committee—Miss Mary A. Brownell, as Chairman—has monthly meetings from November through May each year. Consequently it has been one of the most active working committees. Its principal work during this period has been the preparation of material for a handbook on public health nursing statistics, including the definition of public health nursing services and the special interpretation of these as they relate to records and methods of assembling statistical information. The results of this committee's deliberations are regularly published in the magazine. A new maternity record form has also been printed and is available for purchase.

Service Evaluation Committee — Haven Emerson, M.D., as Chairman—has held 3 meetings. It has acted in an advisory capacity on all questions bearing on the evaluation of public health nursing services rendering upon request interpretation of the 1924 study as presented or later amended. The outstanding activity of the Com-

mittee during this period has been the undertaking of a new study of the cost per unit of nursing service, the Metropolitan Life Insurance Company assisting with the statistical tabulation and the John Hancock Mutual Life Insurance Company making a substantial appropriation toward the publishing of the report. In addition to this study, the Committee authorized the publication of a statement regarding the method of computation of the average number of visits per day and has encouraged local organizations to make calculations on this basis annually.

Revisions Committee — Miss Gertrude H. Bowling as Chairman—has held 3 meetings. The main activity of this Committee has been its recommendations as to the revisions of the by-laws. Some consideration has been given to questions relating to state branches but this will receive more attention during the next Biennial period, in accordance with the action taken by the membership on the by-laws at the 1930 Biennial.

Two special committees have completed their work with outstanding results. The *Board Members' Manual Committee*—Mrs. G. Brown Miller as Chairman—has held 5 all-day meetings and in addition given the greatest amount of time going over the material for the Manual. The result is the final production of this publication in June, 1930. The *Programs and Policies Committee*—Miss Mary S. Gardner as Chairman—has already been reported at length to the membership both in the magazine and in the President's Address.

As previously noted, the two special joint projects with other national bodies—the *Industrial Nursing Project* and the *Social Hygiene Project*—have their own advisory committees to guide the development of these programs.

ORGANIZATION OF STATE GROUPS INTERESTED IN PUBLIC HEALTH NURSING

While effort has been made through correspondence and staff attendance at meetings to keep in touch with the programs of already existing State Associations for Public Health Nursing, there has been a conscious "waiting" policy in regard to any definite activity along these lines until the whole question could be given more careful consideration by the membership and state groups themselves. It seems well at this time briefly to summarize some of the most important considerations involved in this question of the wisest form of state organization for those interested in public health nursing.

1. As a background for the development of any particular activity in which nurses play an important part, it is essential that there should be unity within the professional group itself, as professional standards as such are one of the primary factors on which it must depend. Therefore, all nurses within the state need and should be part of a strong Graduate Nurses' Association.

2. It is believed that much can be accomplished through thinking in terms of state standards for public health nursing and that there should be some means of developing a state consciousness and state-wide responsibility in this regard.

3. To do this it is important to relate lay groups locally interested in public health nursing to a program on a state basis and to give them an opportunity for interchange with others, both professional and lay, working within this larger territory.

4. Any form of organization on a state-wide basis of those active in public health nursing programs should be closely related to the program carried on through the State Department of Health.

5. It is essential that there should be a close and more definite relationship between state groups and the N.O.P.H.N. for the benefit of both. The lack of this in any very tangible form seems to have been one of the weaknesses in our present form of organization of S.O.P.H.N.'s. Granting that in any state the S.O.P.H.N. seems the best means of obtaining the objectives previously outlined, the possibility of developing a scheme whereby there is a combined membership in the state and in the national with combined membership dues should be discussed as offering a practical solution for some of the difficulties of relationship.

For the next Biennial period how best to realize and preserve all of these values at the same time, will receive the most careful consideration.

CONCLUSIONS

The N.O.P.H.N. is the symbol and expression of what is happening in public health nursing in this country—

and less immediately in other countries. Particularly, it is the focal point of the thinking and activities of its own corporate and individual members. Therefore the more inclusive this membership and the more closely the membership is in touch with the N.O.P.H.N. the stronger will be the national body and through it the whole public health nursing movement.

Paradoxical as it may seem, this is the day of emphasis on the importance of both the individual and also on the creative values to be obtained through group association. A national body furthers developments beyond the capacity of any of its individual members and yet is dependent upon this membership for its strength. The more inclusive this membership the stronger in spirit and therefore in accomplishment can the organization become; the greater will be both the tangible and intangible benefits received by those participating. Therefore, the public health nursing movement for its development particularly needs more individual members in the N.O.P.H.N. As far as this relates to public health nurses there is a shocking disproportion between the present nurse membership of considerably less than 5,000 and the estimated number of public health nurses in the country of 20,000. What can reduce this disproportion? Is increased emphasis on direct services and individual returns either the true or sound appeal? These exist to a greater or lesser extent but I do not believe herein rests the importance or value of individual membership. To my mind, a far more important reason is being part of a standard-making body, which because of its national character, can stabilize and interpret the movement as a whole and can create new values and opportunities for its development. No one interested in or part of public health nursing can afford not to be allied to this national organization not so much because of what she may directly receive from such participation in it but because of what she may give in part through this very expression of recognition of the value of group association.

Once again, translating this philosophy into somewhat more practical terms, we believe that the strength of the public health nursing movement depends in large part upon the uniting of the public health nursing agencies, individual public health nurses, board members and workers in allied fields, in a closely knit national organization which expresses and interprets the services of its members, assists them in meeting the community needs, and which is supported by them. The N.O.P.H.N. is not something set apart. It *is* its participating membership reflecting the experience and thinking of each for the benefit of all.

It is your service organization, your research body, your representative, the symbol and focus of your activities. It exists through and for your use and participation so that public health nursing itself may fulfill its opportunities in making health more available for all.

REPORT OF JOINT VOCATIONAL SERVICE, INC.

GRACE L. ANDERSON

For the Representatives of N.O.P.H.N. on the board of Joint Vocational Service

THE first report to a biennial convention from the Joint Vocational Service was made at Louisville two years ago when this new service was less than one and a half years old. It was necessarily a report of the changes, adjustments and challenge incident to the transfer of two old established services from their respective parent organizations to an independent association under the joint auspices of public health nursing and social work groups. In the fourth year of the Service we can bring a report of progress. This joint venture has proved workable in a practical way and we

think it is, in addition, making its contribution to an increasingly better understanding between two closely allied fields. From the beginning, it has been the policy to keep, if possible, all that the two former bureaus had found useful and practical and to make no changes merely for the sake of uniformity. At the same time the organization has been a unit and the policies governing work whether in the public health nursing or social work field have been identical.

During this three and a third years, the volume of work has increased greatly. This is encouraging, but it has also brought pressure and certain problems. With increase in work, fortunately there has also been steady increase in income, but not to the extent that is needed. Each year has seen an increase in the number of candidates registered and number of positions handled as shown by the following table:

	1927		1928		1929	
	Total	P.H.N.	Total	P.H.N.	Total	P.H.N.
Positions handled	2033	711	2258	795	2784	972
Candidates registered	2352	684	2586	837	3029	952

Of the number of public health nursing positions noted as handled in 1928, 659 were closed. Of these 48 per cent were filled. Of the public health nursing positions handled in 1929, 776 were closed. Thirty-seven per cent of these were filled. The 1928 record for placement in an exclusively professional field, is a phenomenal record. The 1929 record, while not as good, is still an excellent one. A review of placement records in professional groups indicates that to fill one-third of the positions handled is a fair average. Two elements enter into the greater difficulty of filling positions in 1929 and these continue through into 1930. The proportion of candidates available for the number of positions reported was very much smaller. Joint Vocational Service actually had a larger number of positions in the public health nursing field than there were candidates registered during 1929. While the service is truly national and positions were reported from every state in the country but one, the location of positions and the locality choice of candidates do not always coincide. Nor does the type of position open necessarily agree with the kind of position wanted by a large group of registrants. We have had more candidates who wanted and are equipped for executive work than there have been executive opportunities. We have had many more calls from rural and small town organizations than we could fill.

Salaries of positions have varied from $1,200 to $5,000. The median in both years has been $1,900. Naturally the largest number of positions are reported from those localities where public health nursing work is more extensively developed. Much assistance has been given to more pioneer sections however and practically every type of public health agency has turned to our office at some time for personnel. The office has made considerable effort to notify candidates of civil service examinations and to supply public departments with lists of candidates who might be interested to take the examination. Positions in the Indian Service and of course in the American Red Cross have been handled.

The other element that contributed to the greater difficulty in filling positions in 1929 was the very heavy load of work without much staff increase. Miss Tittman continues to be our vocational secretary in public health nursing. We have not thus far been able to create a permanent position for a second public health nurse on the staff. In 1930, the budget provides for a full time position for six months. Miss Helen Kienzle of Columbus, Ohio, will begin work the first of July. It is hoped that this will become a full time permanent position next year. We feel sure that given a reasonable length of time, the position would pay for itself.

FINANCE

The budgets adopted by the board have grown from $33,400 in 1927 to $40,900 for 1930. The actual expenses of the organization have grown from $31,500 in 1927 to $39,200 in 1929. We have been able to meet the increased expenses satisfactorily through increased income. Assistance from Foundations meet a little over one-third of our expenses. Fees, one-third of our income, have increased steadily and rapidly, $12,400 being received in 1928 and $14,700 being received in 1929. This 1929 amount is 51 per cent increase over 1927. Income from organizations has also grown, though less rapidly. As you know, the N.O.P.H.N. provides vocational and placement service for its corporate members by voting a grant from its treasury. In the social work field individual agencies subscribe. Our income from organizations has been $10,870 in 1928 to $11,300 in 1929. We must find ways to further increase agency subscriptions or we must tap new sources of income to offset the decreasing foundation support and to provide for growth. This is having the careful consideration of both the finance committee and the board.

Charging a fee to the nurses and social workers placed in a position was a policy adopted with some misgiving. We can say emphatically that it has worked well. There has been very nearly a complete absence of objection to it. Only a small fraction of one per cent has been lost in uncollectable bills during this three and a third year period. In addition many nurses to whom we have not presented a bill for a placement fee, since technically we did not believe the placement was ours, have made voluntary contributions for the service they have received.

BOARD AND COMMITTEE SERVICE

The Board is at present made up of nine representatives each of the National Organization for Public Health Nursing and the American Association of Social Workers and one each from the following national groups:

American Association of Hospital Social Workers.
American Association of Psychiatric Social Workers
American Public Health Association
American Red Cross
Child Welfare League of America
Family Welfare Association of America
National Catholic Welfare Conference, Department of Social Action
National Committee for Mental Hygiene
National Conference of Jewish Social Service
National Tuberculosis Association

Eighty-three different individuals, chiefly public health nurses and social workers are giving time and thought in board and committee membership for J.V.S. Through these board members and through conferences between members of our staff and members of the staffs of other national agencies, there is a much closer knit relationship with these groups than there was two years ago. This is likewise true of the relationship with schools of social work and courses in public health nursing. These strengthened relationships and more frequent conferences have been of value in building up a better body of facts, still inadequate, for those who come to J.V.S. for vocational advice and information and not for a job primarily.

The Advisory Committee on Public Health Nursing with a membership of nineteen, many of whom are resident in or near New York, but some of whom live too far away to attend meetings, has been very active and in close touch with the staff throughout the two years. Records of nurses whom J.V.S. is finding it difficult to serve, records of nurses with special skill and gifts, questions of personnel practice in nursing organizations, are samples of the kind of questions that come to this committee. Names of candidates are never used in committee meeting, the records always being discussed anonymously. We have been very glad this year to have Miss Tucker serve as a regular member of this committee, and to have other members of N.O.P.H.N. staff attend as alternates when she could not. This and the appointment of

Miss Tittman as an ex-officio member of the education committee of N.O.P.H.N., we feel is going to work out helpfully for the candidates and organizations we are trying to serve.

This experiment entered upon three and a third years ago is proving a successful one. J.V.S. is meeting a real need in the public health nursing and social work fields. There is of course much need that is going unmet. We must find ways of increasing our service to distant points in the country, so that they may have as much benefit from J.V.S. facilities as does the East and Middle West. We must be prepared to increase our service to special fields in public health nursing that in the past have made few requests of us, such as the industrial field.

In so far as each member of the N.O.P.H.N., and each member of the other associations that constitute our board, help us remove competition in placement work and centralize this work in the office which they have set up, just so far will this office be strengthened, and the value of its service increased. We believe that vocational guidance and placement is technical work requiring special skill and special facilities of organization. With the wholehearted and intelligent backing of each one of us and only with that can J.V.S. render the fields of public health nursing and social work the amount and quality of assistance in personnel matters that is wanted and needed by both fields.

REPORT OF THE COMMITTEE ON FIELD STUDIES AND ADMINISTRATIVE PRACTICE

The function of the original Committee on Field Studies was to give advice in connection with studies of local nursing services made by the National Organization for Public Health Nursing. This committee considered purposes of study, conclusions to be arrived at, methods of presentation, and schedules for field studies made. The more comprehensive title augments the original scope to include administrative practice and objectives of different types of public health nursing.

This committee functions in a rather curious fashion because of the relationship between it and a similar committee of the Committee on Administrative Practice of the American Public Health Association. The Committee on Administrative Practice works through subcommittees of which public health nursing is one. Because the problems considered by the subcommittee on nursing of the Committee on Administrative Practice are practically the same as the problems considered by the Committee of the National Organization for Public Health Nursing, it was decided that these two committees be practically the same as far as personnel was concerned. These two committees, consequently, with the same set-up, act in relation to both the problems on field studies and administrative practice of the National Organization for Public Health Nursing and the Committee on Administrative Practice of the American Public Health Association.

The scope of the committee has been enlarged to meet the needs that were requisite in acting as the subcommittee on nursing to the Committee on Administrative Practice. Its functions are to consider with the committee of the American Public Health Association questions of administrative practice as they relate to public health nursing, to act as consultant to the Director of Field Studies of the Committee on Administrative Practice on problems of public health nursing, and to assist in keeping the appraisal form up to date.

In relation to the National Organization for Public Health Nursing, this committee will consider questions of policy relating to purpose and method of field studies; it will assemble material relative to the best standards of administrative practice, which may be used to determine the best administrative practices; it will act as advisor to the National Organization for Public Health Nursing staff and members in relation to field studies, and it will be responsible for the revision of the field studies schedule.

The primary function of this committee, consequently, resolves itself into trying to outline objectives of public health nursing of various functional groups and how they may best be administered rather than to outline content and processes, which is one of the objectives of the National Organization for Public Health Nursing itself.

The most important recommendation made by this committee and approved by the Board was that field service, including consultation and field study, be available to those organizations which are on a percentage plan and that credit of 25 per cent of the dues be allocated towards the cost of these services of the National Organization for Public Health Nursing when desired. During this period 11 studies have been made.

Sophie C. Nelson, Chairman

Reports of N.O.P.H.N. Sections

REPORT OF THE N.O.P.H.N. INDUSTRIAL NURSING SECTION

The Section has held one interim meeting during the biennial period 1928–30. This meeting was held in connection with the Industrial Health Division of the National Safety Council at the Safety Congress in Chicago September, 1929, and was very well attended, over a hundred nurses being present at the luncheon and two hundred at the round table meeting. The program included addresses from a safety engineer, a supervisor of industrial relations, a director of a medical department and industrial nurses (see THE PUBLIC HEALTH NURSE, August, 1929, and the proceedings of the National Safety Council, obtainable from the N.O.P.H.N.).

During Convention week a round table which was splendidly attended was devoted to Industrial Nursing and aroused great enthusiasm. Miss Ruth Waterbury, chairman of the Section, presided. The program follows:

Intra-Mural Industrial Nursing Service Provided by a Local Public Health Nursing Organization. Erna Kowalke, R.N., Director of Nursing, Visiting Nurse Association, Milwaukee, Wisconsin.

How a Local Health Organization Can Aid the Nurse in Industry. W. W. Bauer, M.D., Commissioner of Health, Racine, Wisconsin.

The Place of the Nurse in Industry. C. O. Sappington, M.D., Director, Division of Industrial Health, National Safety Council, Chicago, Illinois.

Rural Industrial Health. Hilga S. Nelson, R.N., Supervisory Nurse, Consolidation Coal Company, Fairmont, West Virginia.

Dr. W. W. Bauer's paper is published in this number of the magazine and other addresses will appear in later issues. At the luncheon business meeting Miss Tucker gave a report of the industrial nursing project being carried on by the N.O.P.H.N. which was received with applause, and elicited many questions.

The following officers were elected:

Chairman—2 years

Grace M. Heidel, R.N.
Supervisory Nurse, New York Central Railway Company
Albany, New York

Vice-Chairman, Secretary—2 years

A. M. Lundine, R.N.
Charge Nurse, Cheney Brothers
South Manchester, Conn.

Nurse Members

Ruth C. Waterbury, R.N.
Metropolitan Life Insurance Company
New York City

Marie Brockman
1010 Pine St., St. Louis, Mo.

Wilhelmina A. Carver, R.N.
American Pulley Co.
Philadelphia, Pa.

Hilga S. Nelson, R.N.
Supervising Nurse, Consolidation Coal Co.
Fairmont, W. Va.

Mrs. Kathryn Page, R.N.
The Paraffine Companies
San Francisco, Calif.

Nettie Amundsen, R.N.
Seaman Body Corp.
Milwaukee, Wis.

Honorary Life Member

Mrs. Marion Brockway
Metropolitan Life Insurance Co.
New York City

Lay Members

Mrs. Austin Levy
Harrisville, R. I.

Dr. Wm. Alfred Sawyer
Medical Director, Eastman Kodak Co.
Rochester, N. Y.

G. A. Orth
Chief, Safety and Claims Dept., American Car & Foundry Co.
New York City

James W. Towsen
Industrial Relations Counselors, Inc.
New York City

Of special interest to all public health nurses, especially those employed in industry, was a model of industrial first aid rooms set up on the exhibit floor and staffed by Miss Joanna M. Johnson, R.N., of the Employees Mutual Liability Insurance Company of Wisconsin. Equipment for this model set-up was furnished by a number of local firms.

The arrangement of the rooms was successful not only in demonstrating efficient service but in indicating the opportunities available for health education. The atmosphere of the exhibit suggested the attractive features of a health program rather than the disagreeable ones.

REPORT OF THE N.O.P.H.N. TUBERCULOSIS SECTION

Following the Louisville meeting in June, 1928, letters were sent from the N.O.P.H.N. office to the State Chairmen of the Tuberculosis Section, inviting them to serve for the next biennial period. Forty-six states and the District of Columbia were thus represented. Copies of the Interim Program adopted by the Section in 1927 were submitted to each Chairman to be used as a guide in stimulating interest in tuberculosis in their respective states.

There has been no interim meeting of the Section during this biennial period.

During the past biennial period, the question has been raised, by many of those interested, as to whether at this time a Tuberculosis Nursing Section is the most satisfactory way of furthering the interest of all public health nurses in a tuberculosis program. Increasingly it is being recognized that work for the prevention of tuberculosis has ceased to be so much a separate entity as ramifying throughout every phase of the health movement.

It also has been recognized that several of the activities suggested on the Interim Program should be the responsibility of the National League of Nursing Education.

Therefore, it has been suggested that instead of having a Section on Tuberculosis which supposedly would be composed primarily of those actively engaged in this particular activity, that an Advisory Committee on Tuberculosis, as part of the public health nursing program, be organized. This Committee would be composed of those primarily interested in this subject, distributed throughout the country, and might number anywhere from 7 to 15 as seemed practicable. Its responsibility would be to act as consultant to the N.O.P.H.N. staff in its work of promoting active participation of public health nurses in tuberculosis work and to consider any special problems relating to this field.

Letters embodying this suggested change were sent to the State Chairmen and members of the executive committee of the Section. The replies received from 5 chairmen and 4 members of the executive committee indicate a considerable majority in favor of this proposed change.

With but few exceptions, the reports clearly indicate a duplication of the objectives of the Section with those of other groups in the field, so that the Chairmen have found it difficult to function, except as their program was coördinated with other tuberculosis activities.

At the business meeting of this Section held in Milwaukee, June 11, 1930, it was voted, in view of the facts set forth in this report to discontinue the Tuberculosis Nursing Section and to substitute an advisory committee to be appointed by the N.O.P.H.N.

REPORT OF THE N.O.P.H.N. SCHOOL NURSING SECTION

Report of the activities of the Section for the Biennial period, 1928–1930:

1. An effort was made to secure a rural and an urban adviser on school nursing in every state, but only 24 urban and 18 rural advisers were secured. The object in securing these advisers was to promote a better understanding of the scope, methods, and objectives in school nursing in both lay and professional groups.
2. All these advisers were asked to coöperate in a study of the use of the A.P.H.A. Appraisal Form as a means of evaluating school nursing. A report of the results of this study was presented at the school nursing round table.

Report of the activities during the Convention:

Luncheon meeting—Tuesday, June 10.
Transaction of business.
Election of officers.

Round Table meeting—June 11.
Discussion of means of evaluating school nurse service.
Recommendation was made that the chair appoint a committee for further study of the problem.

Report of election of officers, 1930–1932:

Chairman—Ann Dickie Boyd.

Vice-Chairman—Mary E. Chayer.

Nurse Members of Executive Committee
Mary Hulsizer
Olivia Peterson

Non-Nurse Member—
Dr. J. F. Rogers

Members holding over from last biennial period—
Elma Rood
B. B. Randle
Dr. Edna Bailey

REPORT OF THE N.O.P.H.N. BOARD AND COMMITTEE MEMBERS' SECTION

The Board and Committee Members' Section has grown rapidly since we were welcomed as a definite section of the N.O.P.H.N. at the last Biennial in Louisville.

Following that meeting a letter went to boards of all member agencies telling of the formation of the section and its purpose: to assist committee members with their problems. So great was the interest shown and so many were the demands for help that a secretary for the section became imperative. In September, 1929, Miss Evelyn Davis was appointed as secretary for the N.O.P.H.N. Board and Committee Members' Section at 370 Sevenue Ave. She has spent some time acquainting herself with the work at headquarters and to date has had an opportunity to visit 37 boards of public health nursing agencies in as many cities and towns.

An event of which we are proud is the publication of the Board Members' Manual.* This is the result of two years' work of a committee of board members under the chairmanship of Mrs. G. Brown Miller with the help of the professional staff at headquarters.

The Board Members' Forum in THE PUBLIC HEALTH NURSE magazine has been of great interest and we hope will increase in popularity.

At this convention there are about 100 board members, 84 from communities outside of Milwaukee, representing 22 states and 47 cities and towns. One representative has come all the way from Massachusetts and one—our most distant visitor—from California.

At the business meeting of the section the same officers were reëlected:

Chairman: Mrs. Whitman Cross, Chevy Chase, Maryland
Vice-Chairman: Mrs. C.-E. A. Winslow, New Haven, Connecticut
Directors: Mrs. A. R. Flickwir, Houston, Texas
Alice Griffith, San Francisco, California
Mrs. Richard Noye, Buffalo, New York
Anna M. L. Huber, York, Pennsylvania
Nurse Directors: Ruth Houlton, Minneapolis, Minnesota
Juanita Woods, Richmond, Virginia
Mrs. Ivah Uffelman, Nashville, Tennessee

We have had two round table meetings for board members, a dinner and many informal teas where the Milwaukee lay group were our hostesses and where we discussed our problems well into the dinner hour. The board members also took part in four N.O.P.H.N. round table discussions presenting papers as a part of the general program. Some of these will be published in the Forum.

* May be ordered from N.O.P.H.N. headquarters, $1.25 per copy.

REPORT OF THE N.O.P.H.N. BUSINESS MEETINGS

June 9 and 13, 1930

(Reports of officers are printed elsewhere in this number)

The most important N.O.P.H.N. business presented to the members during Biennial Convention concerned the revision of the by-laws. The proposed revisions covered the following points:

A.N.A. membership as a requirement for N.O.P.H.N. membership.
Similar annual dues for all members.
Similar voting power for all members.
Increasing the Board of Directors from 20 to 21.
Including the Chairman of the Finance Committee as a member of the Board of Directors.
Reducing the standing committees to three and making all others special committees of the Board.

(For the text of the revisions and a discussion of the changes recommended to the membership, see THE PUBLIC HEALTH NURSE, April, 1930.) The revisions were all adopted to go into effect January, 1931,* with the exception of the recommendation to add membership in the American Nurses Association as a requirement for membership in the N.O.P.H.N. This recommendation was lost and the following resolution, adopted by those present at the meeting on June 13, explains the action:

RESOLUTION

WHEREAS, the N.O.P.H.N., at its business session on June 9, 1930, voted to retain its present nurse membership requirement instead of adopting the requirement of A.N.A. membership; and

* Copies of the constitution containing the new by-laws will be distributed before the new year.

WHEREAS, in the discussion of the N.O.P.H.N. membership present, the following points were emphasized and questions raised:

1. That it is very important that public health nurses should be members of their professional organization;

2. That it is open to question whether this desirable end can best be furthered through compulsion or education;

3. That it is questioned whether it is sound organization to make a portion of the membership of one national organization such as the N.O.P.H.N. depend upon membership in another national body;

4. And finally, that in view of the fact that A.N.A. membership is built up on the basis of membership in alumnae associations, which does not seem the desirable unit for membership in a professional organization nor for any allied group;

THEREFORE, BE IT RESOLVED, that this summary of the discussion, which took place in the meeting of the N.O.P.H.N., be presented to the A.N.A. with reaffirmation of our belief in and allegiance to our professional organization and with the suggestion that the A.N.A. give serious consideration to the adoption of a geographical membership basis, beginning with the district association, which would correspond to the plan of membership in other professional bodies, and would remove a practical difficulty, which now stands in the way of a more widespread membership in the A.N.A.

The question of a N.O.P.H.N. biennial convention was considered and the Board of Directors were empowered to arrange for the N.O.P.H.N. meeting in 1932 at such time and place and with such a group as they shall decide. (For the factors involved in this decision, see pp. 211–212, THE PUBLIC HEALTH NURSE, April, 1930.)

The following were elected as officers and directors for the next biennial period—1930–32:

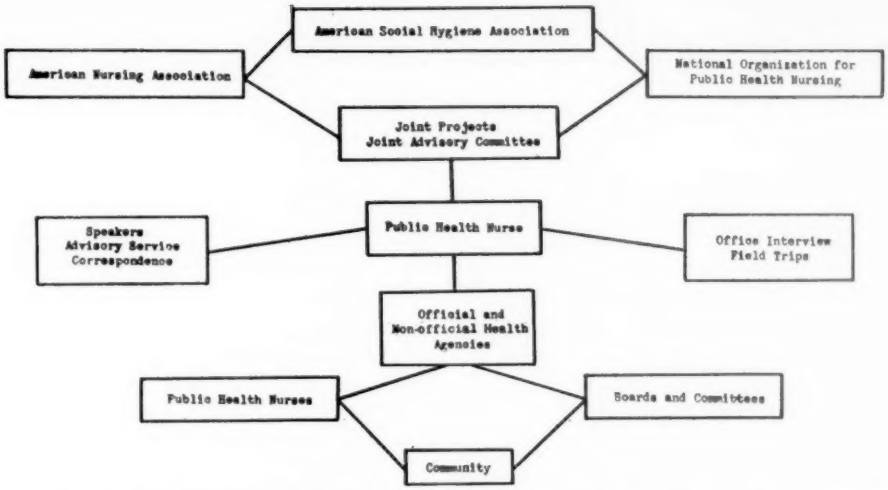
President—Sophie C. Nelson, R.N.
Vice-President—Winifred Rand, R.N.
Second Vice-President—Ruth Houlton, R.N.
Treasurer—Michael Davis.
Directors—Nurse Members—
Amelia Grant
Katharine Faville
Mrs. Anne L. Hansen
Florence M. Patterson
Directors—Sustaining Members—
Dr. E. L. Bishop.
Dr. Haven Emerson.
Gertrude Peabody.
Dr. Miriam Van Waters.
Nominating Committee for 1931
Miriam Ames, R.N.
Grace Anderson, R.N.
Marion G. Crowe, R.N.

THE PLACE OF SOCIAL HYGIENE AT THE BIENNIAL CONVENTION

In the N.O.P.H.N. program, social hygiene was given unprecedented attention. Papers on the responsibility of the public health nurse for preventive measures, detection and control of venereal diseases, were presented at four of the round tables representing population groups, by public health nurses, and an excellent summary of the situation in relation to prevalence and prevention was offered by Dr. Thomas Parran, Jr., Commissioner, New York State Department of Health. We hope to publish Dr. Parran's paper in a later number.

In addition, a booth equipped by the American Social Hygiene Association and presided over by Miss Edna L. Moore, assistant director of the N.O.P.H.N., was visited by hundreds of nurses who studied the miniature demonstration clinic and read the charts with evident interest. Miss Moore reports that many people asked for material for use in schools and Parent-Teacher Associations, and reading lists to extend their own knowledge of this subject. These requests came from superintendents of schools of nursing and private duty nurses as well as public health nurses.

The American Social Hygiene Association in carrying out its policy of coöperating with other agencies has arranged projects with the American Nurses Association and the National Organization for Public Health Nursing. The primary purpose is to bring to the nurses' groups a realization of their opportunities in the field of social hygiene and secondly to help them meet these responsibilities. The diagram shows these relationships.



Write to the American Social Hygiene Association, American Nurses Association, or the National Organization for Public Health Nursing, 370 Seventh Avenue, New York, N. Y., for suggestions and help.

Photo by courtesy of Universal Air Lines

Of Course St. Louis Came by Air!

True to the spirit of St. Louis, these three nurses, Miss Clara Coleman of the City Isolation Hospital, Mrs. Bertha O. Yenicek, Department of Health, and Miss G. E. Webster of the City Hospital No. 1, flew in a Fokker trimotor plane from St. Louis to Chicago in less than three hours en route to the Convention. They report a "thrilling trip."

Administration of a Public Health Service *

By E. L. Bishop, M.D., C.P.H.
State Health Commissioner, Nashville, Tennessee

A BROAD subject such as the Administration of a Public Health Service cannot be encompassed within the time limit set for this paper. It, therefore, becomes necessary to merely mention the elements of a health service, explain the relationship involved, and discuss in more detail those parts of the program which are the primary concern of the public health worker.

There has not as yet been developed a definition for health service which will express the contents of the program. In fact, it is questionable if such a definition can be developed since a complete health program embraces all things which will tend to bring about a more perfect adjustment between the individual and his environment. The very fact that health service is so broad in its scope and so intimately concerned with every phase of human life accounts for the confusion which now exists in its administration. The health worker sees the health aspect in almost every human activity and naturally thinks it should come under his administration. People outside the various professions devoted primarily to health, and notably the social workers, see health service as a mere element in a larger program of social betterment. Time does not permit the further development of these rather abstruse and philosophical considerations. Hence, for the purpose of this paper, health service will be considered as a primary and major activity of organized society to be administered by workers drawn from within the professions involved.

CONTENTS OF HEALTH SERVICE PROGRAM

A health service, to be all inclusive, should provide the means for accomplishing the following purposes:

(1) To prevent disease and disability.
(2) To make life more abundant and perfect.
(3) To restore to health those who have become afflicted with disease or disability.

The first two functions are commonly entitled, the prevention of disease and promotion of health, and the two combined constitute the objectives of most public health agencies. The third element in the program is commonly spoken of as the care of the sick. Generally speaking, the care of the sick is handled by the private practicing physician and the private hospital. The care of the sick poor, however, as well as the care of the more chronic ailments is often financed very largely by taxation and public charity.

DISEASE PREVENTION AND HEALTH PROMOTION

According to the Appraisal Form of the American Public Health Association, the following activities are classed as essential items, common to all public health programs, and discharged in the manner herein specified:

Vital Statistics—The recording of births and deaths occurring in the community and the study of influences which may be factors in bringing on such diseases and disabilities, particularly those of a preventable character.

Control of Acute Communicable Diseases—This is accomplished by lessening the possibility of contact with persons suffering from such diseases, instituting such measures as immunization, which will increase the power of resistance of the individual, and providing facilities whereby communicable diseases may be treated in the most effective manner.

Control of Tuberculosis—The plan embraces a careful search of the community for cases and persons in contact with cases, providing facilities for

* Read before the general session of the National Organization for Public Health Nursing, Milwaukee, Wisconsin, June 10, 1930.

diagnosis, nurses to assist in home care, and the hospitalization of suitable cases.

Venereal Disease Control—Provision is made whereby infected individuals may receive adequate treatment and for other control measures which will tend to lessen the possibility of transfer of infection.

Maternity Hygiene—The expectant mothers are afforded facilities for acquiring information concerning the hygiene of this period and nursing service which may also be made available to those who are delivered at home.

Child Hygiene—The child from birth on is under the supervision of a private physician or clinic, and the work of the physician is supplemented by nurses who will periodically instruct mothers in the proper care of children. The work is done through clinics, schools, and other places where children can be examined and parents instructed regarding child care.

Control of Milk and Food Supplies—The various protective measures are thrown around the production and distribution of milk and other food products, and where possible the article may be processed as an additional safeguard.

Water—The water consumed by the public is examined to determine its sanitary quality and all recognized methods of purification are instituted as may be indicated.

Environmental Sanitation—Man's environment is made as healthful as possible, particular attention being given to proper method of excreta disposal, housing and the control of insects which may transmit diseases.

Industrial and Adult Hygiene—Conditions under which individuals labor are made as sanitary and healthful as possible and every safeguard is thrown around the worker in order that his health may be maintained at the maximum degree of efficiency.

Degenerative Diseases—These diseases, such as heart disease, diabetes, kidney disorder, and the malignant conditions, are detected in their incipiency so the patient can be placed in position to institute such corrective work as may be indicated.

Health Education—The essential facts about health and disease are imparted by means of literature, motion picture exhibits, through class-room instruction, and more particularly in public health clinics and conferences.

Mental Hygiene finds a place in many public health programs. However, it has not as yet been incorporated as an item of routine.

RESPONSIBILITY FOR HEALTH PROGRAM

It may be seen from the above outline of a public health program that the responsibility of the health organization varies with the service and the same is true of the community. For example, the control of communicable diseases is essentially a responsibility of the health department, but at that most of the treatment work is done by the private practicing physician. In the case of water, the health department has scarcely any responsibility except that of analysis of the samples in order to determine the sanitary quality. The expense connected with supplying the water is borne by the municipality or by a private corporation and, in turn, charged to the consumer.

The Appraisal Form, therefore, is a measure of community service and not necessarily restricted to the work of the official health agency. Many organizations are concerned with the performance and administration of a plan of community health service. It is, therefore, only natural to find the health officer changing from his former position as a law enforcement officer to that of a community organizer who utilizes the facilities and agencies of the community in the prosecution of the public health program. But it must be understood that an effective health organization cannot be instituted by attempting to piece together a multiplicity of independent agencies with no more compelling force than a desire to coöperate. The fact remains that the official health officer is the per-

son charged by law with the protection of the public health of the community and this responsibility cannot be avoided even though other agencies may be performing many of the essential services. It is impossible to consider the various agencies and organizations which may be concerned in the program. The necessity for brevity, as well as the fact that state and local governments are concerned primarily with and are held legally responsible for the administration of public health service, is the reason for limiting this paper to a consideration of health services as performed by state and local governments.

RELATIONSHIP OF STATE AND LOCAL HEALTH SERVICE

A knowledge of the evolution of public health organization is necessary to an understanding of the present status of its development, present relationships and existing attitudes. Almost from the beginning of our government, certainly from the time when it became recognized that something could be done towards preventing disease, some sort of public health machinery existed, at least on paper. It was called into action in the face of epidemics and not infrequently fell into disuse when the emergency passed. The older sections of the country, particularly in the North Atlantic states, were settled and developed as local communities. This, coupled with the fact that epidemics more frequently than not are confined to localities, accounts in a large measure for the earlier boards of health being built around local units of government. The state health department for the most part is a more recent institution.

Public health service in the larger cities, even today, is considered a local function and is often jealously guarded as such, even though there be no statutory distinction between the several political subdivisions of the state in their relationship to the state government. Up to the present time in many states the public health service of the smaller cities and the rural areas is rendered directly by the state health department. A more recent development is the decentralized plan of administration, using the county as a unit, but such health departments for the most part have been promoted by state and national organizations. Broadly speaking, then, the public health service of the larger cities continues essentially as a local function and has been developed as such to quite a high degree, while in the smaller cities and the rural areas the service is delivered by the state health department personnel or by a local health department which has been promoted and to a large extent is financed by outside agencies. While this is the picture presenting itself today, a definite change is taking place.

STATE AND LOCAL FUNCTIONS

There is now a tendency to allocate functions relating to public health according to the suitability of the agency for performance of such functions. At the present time, it appears to be the opinion of most students of health administration that practically all services to persons and communities of a direct character should be rendered by the local health organization, and that the state should act as a developmental and stabilizing agency and serve the local agency in a consultant capacity. Even the larger cities are coming to recognize that certain services can be rendered to them more efficiently and effectively by the state. In the larger cities and counties there is also a very definite tendency to split the local service into units on a geographical basis and have each district more or less complete in itself. Under such circumstances, it is only natural that the unit must be under some local directing head and that all persons serving in that organization should be responsible to the directing head. Any supervision or consultation service rendered from an outside agency should be with and through the responsible directing head of the local organization. In other words, the supervising nurse in the central office or the chief sanitary engineer cannot have direct administrative charge over local person-

nel of the same professional classification but must instead deal through the person in administrative charge of the local service.

CARE OF THE SICK

The care of the sick should include the following services:

Hospital care for the acutely sick.
Hospital care for the chronically sick and the convalescent.
Custodial care for the infirm and those who are permanently incapacitated.
Ambulatory treatment for persons who are able to come to a treatment center.
Treatment of the sick in homes.

As stated elsewhere, the great bulk of medical service of a treatment character is rendered through private physicians, nurses and hospitals. The care of the sick poor is regarded as a public responsibility, which for the most part is met by taxation, but this service is also supplemented by the various charitable and benevolent organizations. The health department, as such, is not as a rule charged with either the financial or the administrative responsibility for the medical aspects of the treatment service. An exception to this rule, however, is occasionally made in the case of communicable diseases and tuberculosis. The nursing branch of the public health service quite frequently is involved in the treatment program, particularly the home nursing care. For this reason it becomes necessary to consider the nursing service in its relationship to both the preventive and the treatment aspects of the general health program.

ADMINISTRATION OF NURSING SERVICE

The bedside care type of service is most frequently under private auspices. The public health or instructive type of nursing is, as a rule, directly under the public health agency and under the immediate charge of the official health officer. The combined type of nursing service may be under the auspices of an official health department or under a private organization holding a contract of some sort with the local government and other organizations using the service.

In communities where a distinct nursing organization has been set up apart from the other elements of the community health service, a board usually exercises the general administrative functions and the nursing agency is then responsible to the health officer only for services of a public health character. The sick are considered in the nature of distinct services performed for other agencies and not coming within the jurisdiction of the health officer. In other words, under such circumstances the nursing service becomes a distinct and self-contained unit considering itself responsible to the health officer only insofar as the fulfillment of the contract may be concerned.

With the development of bureaus or departments of nursing in the state health department there has been a tendency to forget the relationship which should exist between state and local governments. When a nursing service is developed locally, particularly if the state is contributing financially, the state supervising nurse feels the only method of insuring the proper type of work is to exert direct administrative control with little or no regard to the prerogatives of the local health officer. In other words, we find a sort of anomalous arrangement whereby nurses are employed locally, serving a local community, for which the local health officer is legally responsible and yet the professional and administrative control of the local nursing personnel is not in his own hands but rather in the hands of the state supervising nurse.

ADMINISTRATIVE PROBLEMS

It is quite beyond the point to devote any time to the necessity of the nurse in the public health program, since it may at this time be assumed that the nurse is indispensable. On the other hand, there is no denying the fact that the public health nurse has constituted a problem in public health administration. Of course, there are many reasons for this situation and much of it is to be expected, since any newcomer

in an organization, such as the nurse is in the public health scheme, finds difficulty in making the necessary adjustments and in finding the proper sphere of action and influence. Probably the chief cause of the trouble has been the tendency on the part of public health personnel to regard public health service as being composed of an endless number of distinct types of service, each being so highly specialized that it must be administered by one of the guild. After all, in the final analysis, there are but two distinct and basic approaches to the solution of public health problems: One, control of the physical environment—this is essentially a problem in engineering; the other, the medical aspects of adjustment of the individual to the environment. All branches of public health service are elements of these two main avenues of approach to the problem. As a sign of the realization of these facts, there will be noted a simplification in the administrative set-up of most health departments. The multiplicity of bureaus and divisions, each under the charge of a specialist, is gradually being supplanted by a more simple type of organization.

The plan of organization most frequently recommended today is one composed of four bureaus: Administration, which includes records, statistics and education; Medical Service, which includes communicable disease control, nursing service, and all other specialties related to medical service; Sanitation, which includes milk, water, food, housing and similar items in environmental control; and Laboratory Service. And finally the whole question of relationship which should obtain between central and local health agencies is not as yet understood by many persons in administrative positions.

PROBABLE FUTURE TREND

We may assume that public health service will be accepted more and more as a responsibility of government and it is natural that these services will be administered very largely as are other functions of government. According to our plan of government, there are three elements: federal, state and local. The federal government, while having a responsibility for local health service, will probably discharge this function by means of research, by consultation service and financial aid through state governments. If the trend in the administration of state highways and education may be accepted as pointing the way, the safe assumption is that state health departments will have three main functions:

General consultation and supervisory services to local health departments.

Financial aid in the development and support of local health services.

The performance of a few state-wide services which can be administered more effectively and economically in this manner.

The essential elements in the health program from the standpoint of delivery of service to the individual and the community will be built around the local units of government. For various reasons, basically economic and social, there will be a greater utilization of larger units of population. The average county, with its contained cities, is quite admirably suited to the newer type of public health organization, because of its larger financial resources and the fact that the county, more frequently than any other unit of population, becomes a complete social and economic unit.

Another probable development will be the creation of better understanding between public health workers and practicing physicians. In the past, preventive measures were concerned solely with environmental sanitation, and the enforcement of certain police regulations. The doctor could assume full responsibility for the patient, since neither a community organization nor institutional facilities were needed in the administration of remedies then available. At the present time, however, the prevention of disease involves the administration of sera and vaccine, the examination of the individual for the detection of maladies in their incipiency and the correction of physical defects which later on may cause serious disability. The cure of disease,

in like manner, has changed very markedly from the prescribing of medicine to something much broader which may involve special institutional facilities, a change of occupation, instruction in correct methods of living, or a variety of non-medicinal remedies. The practicing physician and the private nurses, as well as the private hospital, will constitute the principal arm of the service, both from the point of view of prevention and treatment, yet they are not sufficient in themselves. People are so constituted that they are not apt to apply preventive measures unless the facilities are readily available. A large element of the population is not in position to purchase the type of medical service essential for their cure. It may become necessary for the public agency to supply practitioners of medicine with many facilities required if the people are to profit by advances in scientific knowledge.

The public health nursing service has been developing along the generalized district plan which incorporates the instructive and the bedside type of visit. Heretofore, health officers have been rather reluctant to assume any great responsibility for the bedside type of service and this element of the nursing program has been developed very largely independent of public supervision. As a result, there has been created in the minds of some a notion that bedside service should be conducted independent of public control in order to be free to serve all agencies. The health officer has a basis for his hesitancy in accepting responsibility for bedside nursing service, for the very definite reason that related branches of the medical service have not been correlated with the health program.

It is not too much to expect, however, that with careful planning and with a sympathetic understanding of the community problems by the nurse, the health officer and the private practitioner of medicine, the near future will bring constructive advance in the solution not only of the administration of public health and visiting nursing but in related medical service problems.

This advance can, unquestionably, be most readily attained through unified administrative direction of the services rendered by public agencies for only in this way may the relationships be so simplified as to result in the essential understanding between the public health workers, practitioners of medicine and the public which is to be served.

The Durable Satisfactions of the Nurse's Career—an address by Glenn Frank, President of the University of Wisconsin, was presented at the opening joint session of the Biennial Convention and is printed in full in the *American Journal of Nursing* for July. Limited space allows only the briefest summary of Dr. Frank's very inspiring address:

> The work of the trained nurse has difficulty enough in it to give one a sense of adventure while doing it and a sense of mastery when it is done.
>
> The work of the trained nurse affords routine and variety mixed in satisfactory proportions.
>
> The work of the trained nurse means continuous contact with congenial associates.
>
> The work of the trained nurse gives her the opportunity to create something she can claim as a personal accomplishment.
>
> The nurse has the chance to make two important contributions to medical service:
>
> She can help materially to restore the now somewhat disturbed balance between the science of medicine and the art of medicine.
>
> She can add to the doctor's intermittent ministry to the patient's body a more sustained ministry to the patient's mind.

Finally Dr. Frank urged that "the training period for the profession should not be left as simply a source of cheap labor for hospitals. . . . Society must provide well for the training of nurses for the specialized field of public health service. And our great educational centers must coöperate with the vast array of small hospitals in the development of better training programs for that army of less highly trained nurses for whom a distinct public need exists."

Resources for Health Teaching *

By Adelbert A. Thomas
Associate, School Service, Cleanliness Institute, New York City

IT might be well before we go into this discussion of resources for health teaching to state briefly what is meant by health education. The definition given by the Joint Committee on Health Problems in Education in their report published in 1924 reads:

"Health education can be promoted only by emphasizing all aspects of health; physical, mental, social and moral. The ideal of health is not mere freedom from obvious deformities and pathological symptoms, it is the realization of the highest physical, mental and spiritual possibilities of the individual."

Again, from "Health Behavior" by Drs. Wood and Lerrigo:

"Health education is the sum of experiences, in school and elsewhere, which favorably influence habits, attitudes and knowledge relating to individual, community, and racial health."

Each of us has his own definition of what health education is. If health is life, abundant life, and education is—according to Webster—the impartation or acquisition of knowledge, skill or development of character—I think we might say that health education is learning how to live.

WHO SHALL TEACH HEALTH?

There is no one group charged specifically with the problem of imparting the knowledge of how to live. Public health nurses have long seen responsibility in this direction, the health officer is charged with the responsibility for health education in the community, the father and mother certainly have the responsibility in the home, and the teacher in her classroom. There is no "corner" on who shall teach health education.

What shall we teach? Since it is not the purpose of this talk to go into the details of this phase of the subject, we might briefly say that we are interested in teaching sound scientific truths which can be understood by all.

Who shall receive this education? Children, parents, teachers, the general public.

How shall we teach? We will discuss two resources for health teaching—one, human resources, and the other, material resources.

HUMAN RESOURCES

The people in a community are the human resources. Human resources are valuable from two angles. First, because of the material aid which they give you in carrying out the details of your program, and second, because every time they assist you they are being educated themselves. Witness the enthusiasm and the interest of your lay board because you have given them an opportunity to carry out the program in their community. Since people are more easily reached in a group, let us enumerate the groups that you will find in the average community: Parent-Teacher Association—Junior League—Women's Clubs—Men's Clubs—Y.W.C.A.—Y.M.C.A.—Church Organizations—and in rural communities your Farm Bureau—and through them your 4-H clubs. All organized groups are there in the community waiting for you to work with them. It should be the ambition of every public health nurse to leave a community at least conscious of its responsibility in matters relating to health. Your time would be well spent if you devoted the first month in a community to learning something about the various groups there. Afterward, you are ready to begin your campaign. If, when you leave your work to go on to other fields, you have left in each organization—let us say, a Chairman of Health—you have done a vital and important piece of work.

I have actually heard individual nurses who said they didn't have time to go to teachers' meetings, they didn't

* Address presented at the N.O.P.H.N. General Session, Biennial Convention, Milwaukee, Wis., June 13, 1930.

have time to go to the Women's Club, or they didn't have time to attend the missionary meetings. You cannot afford *not* to have the time to do this thing, if you value your human resources for health education.

USING HUMAN RESOURCES

My work, until the last few months, has been in Kentucky, so my experiences will be largely drawn from there. I know a certain community where the nurse told me that she couldn't get anything done in the way of follow-up or correction of defects because she had no way of reaching the parents except through individual home visits, which, of course, was a long and tedious task. I said to her—"What is the matter with your Mothers' Club or Parent-Teacher Association?"—and she replied, "Oh, they don't have them here"—"Why not?" "Because there isn't an afternoon in the week when there isn't some sort of missionary meeting or church meeting." I said to her, "Well, why not go to those meetings and talk to the mothers there? After all, the women of your community—the mothers whom you wish to meet—are in those church organizations. Just because your mother is attending a missionary society meeting, doesn't make her any less the mother of the child that you are interested in getting glasses for."

And so she started on that basis—working with the organizations that did exist in her community. This is one of the first lessons for any of us to learn if we are interested in doing a good job.

Perhaps the most enlightening experience I have ever had in this connection was my work with the Rotary Clubs in Kentucky. As you all know Rotary Clubs throughout the country have been interested in helping crippled children. The group in Kentucky felt that they had safely launched this work and no longer needed to devote the major portion of their attention and interest to it and looked around for another legitimate interest. Kentucky has been surveyed until the word survey had become odious. The last, and perhaps most elaborate, survey had been conducted by the General Education Board. So when someone suggested that the Rotary Club members survey the schools, the suggestion was met with a great deal of consternation, not only on the part of members themselves, but on the part of the leading educators of the State. However, after much discussion, it was finally agreed that the Rotarians would make a physical, health and sanitary survey of the schools of their respective counties. I was loaned from the State Board of Health to direct the survey. This meant going to each Rotary Club, explaining the purpose of the survey, what they were to look for, and the significance of what they saw. One of the questions asked each club was—"How many of you have read the report of the survey made by the General Education Board?" and except for a few educators, there was scarcely a member in any club who had read that report. The purpose of the survey made by the General Education Board was to present to the general public the condition of the schools and the educational needs of the State, yet it failed to obtain their interest. Why? Because it is human to find the program in which we have had a living part, of greater interest than that which is presented to us as a finished product.

Rotary members went at the survey with enthusiasm—men rode for a day on horse back to reach the schools in their county. All of them took at least a half-day from their work. Many of them who had not been in a school since they left it as students were amazed to see in many instances the same conditions, physical and sanitary, which were there when they left. Many told me they hadn't any idea that there were unjacketed stoves, buckets and dippers still in existence. Almost all were "sold" on educational needs as they could never have been by reading the report from the printed page. I repeat—human resources have the greatest potentialities for health education.

Here are some specific ways in which various organizations have served in furthering the health education program of a community. Parent-Teacher Associations are especially valuable in the program for follow-up and correction of defects, for in a group you can say to them many things which might be difficult to say individually. Your Junior League is important because usually the members of this organization have more leisure than other groups and they can serve as clinic aids in motor corps work. Your Women's Clubs ought to have the maternity work as their legitimate interest. I have just pointed out one of the ways in which a Men's Club might be useful. One of the points we made with the Rotary Clubs was that we were not raising funds or asking for any concerted action, but rather were trying to create an interest in schools and a consciousness of the problems in their own communities. It isn't well to go before a group always asking for money or material things. Money and your material aid will come if you can first of all create an interest.

The Teachers' Association is important, because the classroom program is carried by teachers. Home Economics teachers are especially valuable if you are promoting hot lunches It ought to be a part of your platform to see that every Home Economics teacher is either directly in charge of the lunchroom of your schools or is acting as an adviser or supervisor. We have seen countless instances where a school lunch, started with the best of intentions, becomes a real menace to the health program, because it is run without a realization of the lunchroom's place in the health education program. Associations of various types in your community, such as the Dental Association, the Tuberculosis Association, are all valuable. Each organization should serve to strengthen what you are trying to do. No matter what you feel, or how many programs you have in your heart which you would rather see promoted, you must use that agency which is already established and work through it toward the ultimate goal which you have in mind. Every public health nurse should feel that "All roads lead to Rome."

MATERIAL RESOURCES

In material resources, I include those factors which are found in the environment which can be used in health education, and literature. If you suddenly found yourself on a desert island with a small child to care for, what would you do? You would use the things that you found on that desert island to care for that child, to educate him and to promote his welfare. We are too often in the position of being surrounded by splendid material which we do not see.

How many times have you been asked by a teacher for material on a given subject, and have said to her—"I don't believe I have anything, Miss Smith," when right at your door there was the most usable material? There are many things in every community that will make splendid, graphic, illustrative material for health teaching. First the water supply. Whether it comes from great reservoirs controlled by a water company, or from wells—every community has a water supply. Every community has a problem of garbage disposal. In a big city it may mean that you have an incinerator, which older children can visit. In your small communities it will mean that the children can actually assist with the proper disposal of the garbage.

In your school itself you have a water supply, toilets, heating, lighting, ventilation, cleanliness—all a part of health education, and yet many times overlooked as teaching material. Modern factories, model dairies, laboratories, all serve to illustrate what I mean by environmental resources. I do not mean that you actually will take students to visit a model dairy, or to investigate the local water supply, but I do mean that you should have tucked away in your mind these environmental resources so that when you are asked for material you can immediately say, "Why not take your children to

Mr. ——'s dairy?"—being sure, of course, that Mr. ——'s dairy will bear inspection. "Why not take the children to the Water Works," etc.

In your visits to schools and in talks to children, are you very sure that when you tell a child to do a thing, that he is able to do it? When you tell children to wash their hands after the toilet and before eating, are you sure that he can wash at school? I have visited many schools where the teacher has taught from the text book the menace of the common drinking cup and yet those very children had to get their drink from a bucket with a dipper. They could at least have been taught to make paper cups. To me one of the most important things in health education is to keep it sane and logical. Surroundings should substantiate your health teaching. If they don't, change them!

HEALTH LITERATURE

We are overwhelmed today with health literature, some of it good, some bad, some indifferent. How shall we decide which shall be passed on to the teachers and children, to the community at large, and which shall be consigned to the waste paper basket? You have a responsibility in this connection. All literature relating to health must be sound scientifically and educationally.* For the schools it must be graded according to the needs of the children, for the community it must be suited to the understanding of the individuals who are to read it. This is fundamental. Much has been written on the subject of health education materials and many very learned persons are giving us standards by which we can test the worthwhileness of the publications which are flooding the country. You can receive help from these sources. A very practical plan for selecting material which will go into the schools particularly, is to have a committee on literature composed of teachers and yourself: the teachers to pass on its educational value, and whether it is graded according to the needs of the children, you to pass on whether it is scientifically sound. The teachers and the community have the right to expect of you this type of service. If something gets into the hands of children which is not sound scientifically, you really are responsible.

You may remember the old saying "It is better to have a little material used a lot, than a lot of material used a little." If your teachers pass on the material to be used in school you will find them using it instead of consigning it to the shelves. If we remember that a child is being educated constantly by his surroundings, through the motion pictures, through community activities, by his contact with adults and other children, we will realize that what he gets from the printed page must supplement, correct, interpret and enlarge these life experiences and points of view. If we conceive of education as a process by which children are changed in ways which make for fuller and better living, we will look upon all material with this question, "Will this produce the desired changes, will this give the child the necessary health knowledge, will it help him to build and to persist in good health habits, and will it enlist his active attitude toward health?"

My plea is that in the stress of the moment, we do not forget the whole picture. Weighing and measuring is important. Immunization is important, but not to the exclusion of everything else. There may come a time during an epidemic or a scare, when all of our attention is given to one thing—but we, in whose hands is placed the responsibility for carrying on the whole program, must never lose sight of the whole program. And here I am moved to say that there is the greatest fallacy current in the United States—that of examining children each year without adequate follow-up and correction. Why go on examining and reëxamining children and finding and

* *Editorial note:* The National Organization for Public Health Nursing will be glad to suggest sources of health education literature.

refinding the same defects? Some communities have solved this problem of adequate follow-up by examining only in stated years, thus allowing time for corrective work. Some day we hope all communities will solve this problem. Until then, our great hope is to use our human resources.

In the days of this conference you have heard many papers on a variety of subjects and perhaps terminology that is new to you. May I say that whether you say health habits or health behavior, whether you say the habit comes first or the attitude first, really doesn't make a great deal of difference—the important thing is not to let terminology obscure the real purpose. At present popular terms in health education are "correlate," "motivate," "negative teaching." Go to a medical meeting, a dental meeting, a meeting of teachers and you will find the same thing happening. If we are wise, we will sit down and ask ourselves the question—"Does this really mean anything different—is it new, or is it simply another way of saying the same thing?" I think the importance of this in relation to our community program is that we go to conventions and meetings and come back to our home community filled with new ideas and new words which we promptly try out on our home group. It is confusing to the general public to have terms changed from year to year. Let us get the new point of view or idea, but let us use a little common sense, and perhaps a sense of humor in this matter of terminology.

An important thing to remember in connection with a community program is that a knowledge of the other fellow's job is extremely helpful; for example, of such organizations as the Farm Bureau, the work of the Extension Department of the State University, with their 4-H Clubs. One of those h's stands for health and we ought to be conversant with the program.

In closing let us not forget that: "Nothing is good enough for children but the best."

"The responsibility for Publicity in a private organization is best headed up in a publicity committee of three or five, working with the President and at times, the Treasurer of the association. A paid worker should be employed. We have all travelled far from that early idea that anyone can do publicity. *Anyone can't.* Publicity is just as much a profession as our own. I realize, of course, that many an association does not feel it can legitimately spend $3,000 to $5,000 a year for a full-time publicity person. I firmly believe that part-time publicity consultants are a solution of our problem.

"In the Visiting Nurse Association of Brooklyn we have two part-time consultants working hand in hand. One is our newspaper woman, an ex-reporter with a wide acquaintance among the editors of the city. She gives us two news or feature stories, each month. We engage her for six months. The expense comes to a total of $200 for newspaper work. We also have a general publicity person who gives one afternoon a week for an eight months' period, the total cost of this service to us is $600. Our association is in effect receiving for $800 the benefit of personnel that at full-time would cost from $7,000 to $9,000."

—*Notes from a paper on Publicity by Elizabeth Stringer, Director, Brooklyn Visiting Nurse Association*

OFFICIAL REGISTRATION AT THE BIENNIAL CONVENTION

Total Registration	4,287
Student Registration	286
N.O.P.H.N. Board Members	100

The Citizen's Responsibility for Community Health *

By Michael M. Davis
Director for Medical Services, Julius Rosenwald Fund

CITIZENS are tax payers or rent payers, fathers or mothers, employers or employees. In all these capacities the citizen's first responsibility for community health is to know what he and his fellow citizens are spending for health and what they are getting for their money. On the average, American cities and towns are spending less than $1 per head for preventing disease, but more than $25 per head trying to cure it. In the nation as a whole, we are spending between 2½ and 3 billion dollars a year for the care of illness and less than 100 million dollars a year for prevention. Children still die of diphtheria despite the fact that there are well-known methods of modern medicine whereby every child at a trifling expense can be made safe from this terrible disease. Typhoid fever, malaria, hook-worm disease, syphilis, gonorrhea, tuberculosis and the needless deaths of mothers and babies still cost this country millions of unnecessary dollars annually. Citizens are taking out of tax funds and their private pockets every year about a quarter of a billion dollars for building hospitals to care for sick people and this is more than twice as much money as they are permitting their public departments and voluntary health organizations to spend for preventing sickness.

The citizen's responsibility for health begins by being intelligent enough about it to see that he gets a dollar's worth for the dollar that he spends as an individual or as a tax payer; to know that if the health department in his town receives only 50 cents per head of population the town may expect a bigger bill for sickness and death to come directly or indirectly out of the pockets of its citizens. A health department which spends three times that amount is really cheaper. The informed citizen knows that a good health department does not imply a salary of $50 or $100 a month paid to a physician to devote a few hours out of a busy private practice to attend to what is really the full-time job of a specially trained man. The citizen should know that a good health department means a trained professional head who will keep his eye on public health and not on local politics, and who will have a large enough staff of nurses, inspectors and other helpers to insure his community good milk and water supplies, proper control of infectious diseases, and facilities for applying the best of modern science in minimizing tuberculosis, venereal diseases, maternal and infant mortality and diseases and defects among school children.

The Responsible Citizen

The citizen who carries out his responsibility for community health knows how to spend his money when sickness befalls him or his family. He knows that physicians are only human, but he turns to the physician and not to the chiropractor or the healer. He will not contribute much to the three-fourths of a billion dollars which the people of the United States lay out annually for drugs and medicines, largely worthless. In selecting a physician, whether a general practitioner or a specialist, he will either seek the family physician in whom he has had confidence for years, or if he has not such a contact, he will choose a doctor upon the advice of his local health officer or of the superintendent of his neighboring hospital, rather than depend upon the suggestions of his grandmother or of his seat-mate at the Rotary Club.

* Abstract of paper presented at the dinner meeting of the N.O.P.H.N. Board and Committee Members' Section, Biennial Convention, Milwaukee, Wis., June 11, 1930.

Before he gives money to the building or support of hospitals he will ask what standards they have maintained as judged by national professional bodies such as the American Medical Association or the American College of Surgeons, instead of relying on statements made in the furore of publicity campaigns. If he is an employer, he will appreciate that the health of his employees is the prime condition of their efficiency as workers and that dollars wisely spent by or for the workers for the promotion of health or for good medical service will contribute more to dividends than they will to deficits on the balance sheet.

THE PLACE OF NURSING

Where does nursing fit into the picture of community health?

We know that effective application of modern knowledge to the prevention of disease requires about one public health nurse to every two thousand population. There is no measure that is cheaper than public health nursing in comparison with the results which it achieves. If the people of the United States spent annually for public health nursing one-twelfth as much as they now spend for cigarettes, the health and happiness of millions of people in this country, particularly of women and children, would be literally transformed.

HOW TO MEET THE EXPENSE OF NURSING

With skilled nursing service for the sick the great difficulty is its cost. Hospitals are expensive luxuries even when available, and only about one-tenth of all incapacitating sickness at present finds its way to hospital doors. All serious illness at home and much chronic illness, needs skilled nursing. But the full time of a well-trained nurse means $30 or $40 a week in cash outlay besides board and lodging, and this is higher than the weekly earnings of millions of our citizens and quite out of the reach of most of them. From the standpoint of the trained nurse herself, it is a paradox that a wage scale of $7 a day, which patients complain is too expensive, usually means a yearly income for the nurse of only about $1,200 or $1,300. This is not because of bad arithmetic, but because the work of the private nurse is generally uneven and uncertain. She has slack periods when she is not employed and her supposedly high day rate often hardly makes a minimum living income the year around. Hence the curious fact that we have a shortage of skilled nursing in the homes of the sick of the country, although there may be and often is a surplus of nurses.

The solution of this riddle must be found through the American genius for organization. The private nurse is still in the stage of peddling her services to the doctors and patients who will employ her. The days of peddling ought to be as far past for the modern nurse as the days of saddlebag medicine are for the doctor. Comparatively few sick people need the full-time services of a nurse either in the hospital or in the home. The organizing skill of American men and women must arrange so that trained nursing can be bought by the piece instead of merely by the person. Hourly nursing must be available for the thousands of families who would purchase it if they could from the visiting nurse association, not as a charity but on a business basis, paying its cost, from a well-organized central agency in each city and town.

Only slight beginnings have as yet been made in developing hourly nursing and most of these beginnings have been blurred by the connection with charity which kindly persons are dispensing through organized nursing services in the homes of the sick poor. Some hourly nursing experiments also have been impossibly expensive because they have been organized on a petty scale. The nursing profession and the lay citizens behind them need to realize their responsibilities for community health and to meet the challenge to organize their communities so that the inestimable benefits of skilled nursing shall be available to all the people without charity and without profit.

Co-ordination of Nursing Resources in a Community*

By M. Josephine Smith
Central Committee on Nursing, Cleveland, Ohio

THE Central Committee on Nursing in Cleveland was born in April, 1914, although for the first ten years of its life it was known as the Central Committee on Public Health Nursing and its membership and activities were confined to the public health nursing groups. However, when Dr. Haven Emerson made his Cleveland Hospital and Health Survey he expressed the belief that the activities of the Committee should be extended; and the way was opened to do this when, in 1923, the Red Cross asked the Committee to take over the task of supplying students for the schools of nursing of the city. In response to this request the Central Committee took over the Red Cross Student Nurse Recruiting Committee, which consisted of the directors of all the accredited schools of nursing in the city, together with certain lay people especially connected with and interested in the problems of nursing education; and it became a Sub-Committee on Nursing Education.

In the sketch of what those services have been it must be borne in mind that the Committee has been an accepted part of the public health nursing organization of Cleveland for sixteen years; whereas its share in the institutional organization of the city began only six years ago; therefore the results achieved in the former field are much more complete and the work is much better organized than in the latter.

The Central Committee has had in mind, from the beginning, certain clear and important objects; these may be broadly outlined as follows:

To coördinate, as far as possible, the various nursing organizations of the city.

To maintain equal standards of high professional training as a requirement of all the organizations represented.

To provide a meeting ground for the discussion of matters affecting nursing service, from the point of view of the public served as well as that of the nurse giving the service.

To promote efficiency and economy in the provision of personnel to staff the various organizations; and to make the experience of one group available for the use and benefit of all.

TO COORDINATE ALL NURSING ORGANIZATIONS

So far as the public health nursing organizations are concerned, there is probably no part of the Central Committee's aspirations which has been more successfully achieved than that of coördination. It is not boastful, I think, to say that Cleveland is known for the coöperative spirit of its public health nursing groups; how far this is due to the very friendly and close relationship which has existed for so many years between the superintendents of the various staffs in their constant meeting as members of the Central Committee; or how far the possibility of these friendly relations in the Committee is due to the coöperative spirit abroad in Cleveland, someone else must decide. One thing is beyond dispute, however, and that is that no meetings could be more frank in discussion or more cordial in spirit than those of the public health nursing committee; and it would be difficult to say how many possible causes of contention have been removed almost before they were perceived, through the informal conversations between individuals, as well as the group discussions at those meetings.

The membership of this group is very complete, for it includes representatives from all the public health

* Abstracts from paper presented at the joint session of the National Nursing Organizations' Biennial Convention, Milwaukee, Wis., June 10, 1930. Printed in full in the *American Journal of Nursing*, July, 1930.

nursing organizations of the city—the Health Division, the Board of Education, the Visiting Nurse Association, the University Public Health Nursing Station, the Dispensaries of Maternity Hospital and the Babies' and Children's Hospital, and the Red Cross Teaching Center. The representatives are, in each case, the Director of Nursing Service and a board member appointed annually by the member organization; in the case of the City Health Division the Commissioner of Health is a permanent member, and so is also the Medical Chief of the School Health Service.

In the hospital field the membership is also complete, if we exclude the private hospitals. The Nursing Superintendents of fourteen hospitals sit on the Committee, and all the accredited Schools of Nursing are represented by their Directors.

TO MAINTAIN STANDARDS

Through all the difficult early years of public health nursing, through the hard times of the War, right up to the present day when high standards of nursing are a *sine qua non*, the Central Committee in Cleveland has maintained one professional standard of admission to all the public health nursing staffs; and any nurse accepted by the Eligibility Committee is, by that fact, professionally eligible to any one of the staffs. In the same way, nurses accepted for institutional work must have the same professional standard of training, no matter for what hospital they are making application. It is interesting to note that there has never at any time been disagreement as to the standard to be required; nor has any effort ever been made on the part of any staff to fall below the standard set by the Central Committee.

Of course, there are some variations as to what the superintendent of a particular staff desires as the background and experience of her nurses, and from that angle every appointment is an individual one; just as any nurse has the privilege of making application for one particular staff.

The Director of the Western Reserve University Course for Public Health Nurses, or her Associate, attends the meetings of the Eligibility Committee, and because of her contact with students who spend two months of their senior year in the University District, as well as with the post graduate students, her assistance is invaluable. More and more, as the local supply of nurses has increased, the Public Health Committee has given preference to graduates of Cleveland schools who have passed through the University District. There is at all times the closest coöperation between the Public Health Committee and the University District.

And here also the Committee on Nursing Education comes in, for it has steadily and definitely worked to make standards of nursing education familiar in the community, by maintaining a bureau of information to which all young women interested in becoming graduate nurses may turn for help; by talks given in colleges, high schools, and to various groups of young women and their parents and guardians. It has also worked to bring all the accredited schools of nursing in the city to the point of accepting as students only full high school graduates; and I am glad to say that this goal has now been reached and no accredited school in Cleveland will accept anything less.

A FORUM FOR DISCUSSION

The Central Committee, because its membership includes lay people as well as professional, provides a meeting ground for the discussion of matters affecting nursing service, from the point of view of those served as well as of those who give the service. At the present day we are hardly allowed to forget the fact that, while the problem of providing efficient nursing service in sufficient amount to care for our sick is being considered and solved as never before, the equally important problem of providing this service at a cost which the patient can afford has not been met in an equal degree. The Committee has been called upon to give some thought to this question, and it is

the logical group to give it still more serious thought in the future.

Some while ago there was in Cleveland a strong feeling among the private duty nurses that the fees charged for their services were incommensurate with the long hours of professional service demanded in return; while, at the same time, it seemed clear that the public could not meet an increase. Although the Central Committee has never entered the field of private or "special" duty nursing, which is taken care of, of course, by the Official Registry, the matter was referred to the Committee for study.

The matter was considered from two angles:

Private nursing in the hospital.
Private nursing in the home.

The deliberations of the Committee on the second point led it to the conclusion that the most practicable way of reducing the cost of nursing service was through an extension of hourly nursing service. There are very few nurses on private duty in Cleveland doing hourly nursing, and because of the high overhead cost of providing such service the Official Registry did not feel able to sponsor an experiment. On the other hand, the Visiting Nurse Association was already doing a considerable amount of hourly nursing at cost price in homes of moderate means and was fully equipped with a well supervised staff to add to its activities what is known as an "appointment service"—that is to say, a service through which a nurse can be sent to a home at the hour desired by the family. On the request of the special study committee the Visiting Nurse Association undertook a year's experiment along these lines, and through the cooperation of the Cleveland Health Council, a very careful statistical study and report was made at the end of the period. The most significant point brought out by the experiment was that, while the demand for the "appointment service" was not very great, there was a considerable increase in the demand for the regular hourly service, which is, of course, much less costly to provide. The service has been continued as a regular part of the Visiting Nursing program, since the demand for it, though small, showed a need and the possibility of further development.

TO PROMOTE EFFICIENCY AND ECONOMY

It is not difficult to demonstrate that time and money are saved if one central agency is doing a piece of work, instead of a number of isolated agencies. The placement bureau of the Central Committee completes and files applications for the public health staffs and hospitals and openings are filled from these lists as they occur.

The Central Committee is a member of the Welfare Federation and is financed through the Community Fund, which is in itself, I think, a sufficient criterion that its work is recognized by the community as important public service and also as a measure of economic efficiency. Its services are free to all organizations and to all nurses who use it; and the more it is used, the more the economy gained.

Of course Cleveland has one outstanding advantage in its Nursing Center, which houses a number of nursing groups and, through its club house facilities gives hospitality to, and constantly brings together all the others; it is, in short, a local 370 Seventh Avenue, and the Central Committee, the Visiting Nurse Association, the Official Registry and the District Headquarters all occupy the very attractive second floor of the Center and can communicate with each other in a few seconds.

This, in very general and prosaic words, is the outline of how the Central Committee on Nursing has attempted to serve and promote the cause of community nursing in Cleveland; but I think if you were to ask its oldest members—those who have grown up into and with it—they would say that its most valuable contribution has been, not the accomplishments which can be demonstrated on paper, but rather, the intangible "esprit" which it has helped to create, and through and because of which, many practical benefits follow as a matter of course.

Public Health Nursing Legislation *

By Pearl McIver

Director of Public Health Nursing, State Board of Health, Missouri

Data on public health nursing legislation may be secured from a variety of sources and by a number of different methods. The most reliable source is the revised or annotated statutes of the various states. Access to these volumes may be obtained through the library of any law school or through the library of the state capitol. The statutes of each state may be found in the office of the county attorney or in the office of practically any attorney in the community. Finding the laws which relate to public health nursing is not difficult but may require some patience because, though the laws of each state are classified somewhat similarly, the key words under those headings may vary considerably. The usual key words are health, public health, nurse, or school nurse. However, in one state, the permission to employ a school nurse is found under a paragraph headed school budgets. Thus, it is quite possible that some laws have been overlooked in this paper.

When time is limited, the easiest source of information on legislation, as on any public health nursing subject, is the National Organization for Public Health Nursing. This association keeps a file of information on recent changes in public health nursing law, and suggestions as to future needs and types of legislation. The three articles prepared by Dr. James A. Tobey for The Public Health Nurse furnish our best source of accurate information.

Another source of information which may not be as accurate as to content, but which is of very great importance when the effectiveness of existing legislation is to be considered, is the official health department. Personal conferences or correspondence with the directors of these departments will frequently yield information which has been overlooked when consulting other sources.

A STUDY of public health nursing legislation, based on the reports from states collected by James A. Tobey and published in The Public Health Nurse,** reveals the fact that twenty-five years ago no state recognized the public health nurse as a legitimate employee of an official health or educational agency. As early as 1898, Los Angeles had employed a few municipal nurses, and in 1902 the New York City Health Department employed several nurses to assist in the control of communicable diseases, but these instances were more or less in the nature of experiments and were not authorized by legislative action. Recognition of public health nursing as a desirable or necessary function of government is thus an outcome of the last quarter of a century.

The first state to officially approve the employment of public health nurses by governmental agencies was Alabama. The County Health Law passed in 1907 specifically mentions nurses as "employees necessary to accomplish the work of a county health department." The following year, New York state passed a law which permitted the employment of nurses to aid in the control of tuberculosis. Ohio was the third state to recognize the public health nurse by mentioning her in its school health inspection law which was passed in 1909. In 1911, Massachusetts permitted certain cities to employ "visiting nurses" and during that same year Pennsylvania authorized the employment of school nurses.

No further progress was made until 1913, but during the next ten years, from 1913 to 1923, the interest in public health nursing increased rapidly.

** State Laws on Public Health Nursing. James A. Tobey. Public Health Nurse, May, 1930.

A Review of State Laws on Public Health Nursing. James A. Tobey. Public Health Nurse, April, 1923.

Recent State Legislation on Public Health Nursing. James A. Tobey. Public Health Nurse, March, 1926. Also State Laws for Public Health Nursing Committees in Counties. Public Health Nurse, July, 1927.

* Presented at a Joint Session of National Nursing Organizations, Biennial Convention, Milwaukee, Wis., June 10, 1930.

A number of national movements which came to the forefront during that period, contributed much to public health nursing progress, and the effect of these movements is evident in the type of legislation which was promoted by each group?

THE STIMULUS OF NATIONAL MOVEMENTS

One of the first organizations to urge the employment of public health nurses was the National Tuberculosis Association. After the sale of Christmas Seals began and state tuberculosis associations became active in promoting local health programs, these local societies found that public health nurses were useful and necessary. Consequently, many states passed laws which specifically permitted the employment of tuberculosis nurses during the early years of this period.

An organization which did much to focus the attention of public officials on the place which nurses were to play in any well organized public health program was the National Organization for Public Health Nursing, founded in 1912. During the early years of its existence, the organization was especially active in promoting the establishment of visiting nurse associations, many of which were at least partially supported by official funds. The increased interest in school nursing during this period was also largely due to the influence of this organization.

During and following the World War the health statistics obtained by the government aroused a nation-wide interest in the protection of public health. The promotion of rural public health nursing by the American Red Cross, which came as a natural consequence, emphasized the need for official participation in rural public health nursing work and led to the passage of a number of rural public health nursing laws.

EFFECT OF THE FEDERAL MATERNITY AND INFANCY ACT

Coexistent with the interest in the Red Cross nursing services was the demand for better health protection for mothers and babies which led to the passage of the Federal Maternity and Infancy Act in 1921. Perhaps no other single measure has, to such a degree, stimulated the interest of state health departments in nursing. In 1920, there were but seven state divisions of public health nursing, and eleven divisions of child hygiene which were directed by nurses or which employed nurses who had the status of state nursing supervisors. Today there are nine divisions of public health nursing and twenty-four divisions of child hygiene, ten of which are directed by nurses and fourteen which employ nurses to direct the nursing activities of the state. Another important effect of the Maternity and Infancy Act was the interest in local maternity and infancy nursing service, made possible through the matching of state and federal funds with county funds. This frequently necessitated the passage of laws which permitted the use of county funds for nursing work.

Finally, the progress in the establishment of whole-time county health departments, due to the interest of the United States Public Health Service and the International Health Board of the Rockefeller Foundation, further stimulated the employment of public health nurses by county authorities and several general health laws were passed which specifically mentioned the employment of nurses.

LEGAL STATUS OF PUBLIC HEALTH NURSING

In determining the present legal status of public health nursing we find that forty states now have legislation which permits the employment of public health nurses by official agencies. Twenty-three states have laws which permit rural administrative agencies (county, town, or township) to employ nurses for general public health work. Fifteen states have similar legislation for their cities, and twenty states authorize the employment of school nurses. Twelve states definitely refer to tuberculosis work.

It will be noted that eight states have no legislation which explicitly pertains

to public health nursing, although several states, including Arkansas and New Mexico, have laws which permit the employment of "necessary public health personnel," and this would, of course, include nurses. Two of these states (Louisiana and Arizona) reported that the laws of their respective states were sufficiently broad and elastic to permit the employment of any needed personnel and that further legislation was unnecessary. No replies were received from the other states.

Under the heading "Special Legislation" are recorded those laws which deal with the establishment of credential committees, divisions of public health nursing or special activities which are not common to more than one state. In six states (California, Connecticut, Maine, Minnesota, New York and Wisconsin), a definite committee or agency is charged with the responsibility of establishing public health nursing standards or requirements. The committee is sometimes made up of representatives of the state board of health, the state department of education, and the state board of nurse examiners—in other cases the state board of health is charged with the whole responsibility. Two states (Michigan and Kansas) have definite requirements written into their laws. Since requirements are, or should be, continually increasing, it would appear that the best practice would be to leave the responsibility with some definite agency, as it is often difficult to have the statutes amended.

QUALIFICATIONS

Although but eight states have specific laws pertaining to public health nursing credentials, thirty additional states have regulations passed by their respective state health departments which define requirements. Every state health department is empowered to pass rules and regulations which have to do with the protection of public health, and these regulations are usually as effective as laws. Of these thirty, four states specify that all public health nurses shall meet requirements of the National Organization for Public Health Nursing. Twelve states give as the minimum requirements "state registration plus a four months' post-graduate course in public health nursing, or from eight to twelve months of public health nursing experience under adequate supervision." Ten states specify state registration plus "satisfactory public health experience," but do not define that experience. Massachusetts has a civil service requirement; Kentucky requires a "public health nursing course and satisfactory experience," and several others have standards which are advocated but not required.

Only two states have divisions of public health nursing which were created by legislative action. The New York department was created in 1913 and the Kentucky division in 1920. However, as was stated previously, nine states now have divisions of public health nursing and twenty-four states have combined departments of child hygiene and public health nursing which are directed by nurses or which employ state supervising nurses.

The special activities include a midwife supervisor in Delaware, a juvenile court nurse in Iowa, mental hygiene nurses in Indiana, and state board of health nurses in Maryland. Most of these laws were passed at least ten years ago, when specialized services were more general than they are at present.

TREND OF LEGISLATION

The trend which public health nursing legislation has followed since 1923, and which it will no doubt follow during the immediate future, is indicated by several rather broad principles.

First, experience has taught us that, generally speaking, permissive legislation is to be preferred to mandatory laws. Authorities agree that community progress never exceeds the progress made by the majority of the citizens living in that community. Prof. E. L. Morgan, an authority on rural organization at the University of Missouri, says that we should give every community 80 per cent of what it wants and 20 per cent of what we

think it needs, and gradually stimulate within it the desire for what we consider to be the better things. Dr. Rolo Reynolds of Columbia University made a similar statement in a recent lecture on public health publicity. He said:

"In a democracy, people should get what they want. It is our duty to make them want better things, but until that desire has been created, we must let them dictate at least three-fourths of the program."

We cannot legislate a health program, or any other kind of a program, onto a community. We must first create the desire for the program or service, then when the community has that "felt need" it will not be necessary to rely upon mandatory legislation. Wisconsin has tried both types of legislation, and Miss Cornelia Van Kooy, the Director of Public Health Nursing in Wisconsin, gives the following opinion regarding the repeal of the mandatory law:

"Forced measures are not successful because appropriations may not be sufficient to carry out the full intent of the law, and unless there is genuine local interest, the program will be handicapped. Second, a law may make the employment of a nurse mandatory but it cannot compel nurses to accept county positions unless they are willing to do so, and in our state, we found it was not possible to find enough nurses who were capable of selling public health nursing programs which would be more or less permanent."

A second principle which influences the type of legislation is the inherent difference in customs, policies, and constitutions of the states in different sections of the country. For instance, the 46th amendment to Massachusetts' constitution prohibits the granting of official aid to private organizations. In many states, as in Indiana, specific provision is made for giving official aid to private nursing organizations, but such a law would be unconstitutional in Massachusetts. Several states, like Rhode Island, have special legislation permitting certain cities to employ public health nurses, while in most of the western states cities are empowered to make their own regulations on such matters, and special state legislation is unnecessary. Then again, in certain southern states the only type of approved rural health organization is the whole-time county health department, while in many southern states that type of organization does not exist. Thus individual tendencies or sectional policies as well as constitutional differences must be considered when planning legislation for any particular state.

GENERAL AUTHORITY TO A SPECIFIC DEPARTMENT

In the interest of progress, most health administrators believe that legislation which delegates general authority to a specific department or agency is preferable to specific regulations in the statutes. This point has already been mentioned in regard to nursing requirements and it also applies to the naming of maximum salaries and to defining duties. In one instance a state prohibits a county court from paying the public health nurse a salary of more than eighteen hundred dollars per year. That may be a fair salary in certain sections of the country at present, but the time is likely to come when it will not be possible to secure a well qualified nurse for that salary. Another state fixed the salary at one hundred dollars per month, which may have been adequate when the law was passed, but would not be a fair salary today.

California's public health nursing law is considered to be one of the most effective examples of good legislation and it illustrates this point very well. To quote it:

"The Board of Supervisors of any county may employ one or more public health nurses each of whom shall be a registered nurse, possessing such qualifications as may, at the date of her employment, be prescribed by the State Department of Health. Her compensation and duties are to be determined by the Board of Supervisors."

It will be noted that this law implies that there will be special requirements in addition to state registration, and that these requirements will be changed from time to time. No salary is specified, neither are the duties defined, but the responsible agency is named and the well qualified nurse will see

that her Board of Supervisors is kept informed concerning both these items. Incidentally, California has the highest requirements for public health nurses of any state in the Union at present.

PUBLIC HEALTH NURSING AN INTEGRAL PART OF THE PROGRAM

A final factor which will influence public health nursing legislation in the future is the growing tendency to consider public health nursing, not as an isolated activity, but as an integral part of every well rounded public health program. In the past nurses have sometimes been accused of creating an interest in public health nursing but of failing to make their communities realize that nursing is but one phase of a complete health program. An efficient public health nurse knows that the neglect of the sanitary engineering program or the curtailment of the laboratory facilities is as serious a menace to community health as is the reduction of her own staff. She will feel an equal responsibility in promoting every phase of the health program. It may be many years before public health departments are entirely removed from political dominance, but it is well for us to remember that public sentiment and a report of achievement are far more potent factors in guaranteeing the permanency of a service than is the most skillfully drafted law.

Thus, so far as their specialty is concerned, public health nurses should seek that legislation which will be of the greatest benefit to the whole profession of public health, but when legislation which affects the status of professional nursing is to be considered, public health nurses must be vitally concerned. The title "R.N." must mean that the nurse has had at least a high school education and that she has had a complete, well rounded nursing experience or she will not be capable of securing that additional preparation which is needed for public health nursing work.

The National Organization for Public Health Nursing, from which much of this material has been secured, is interested in all state legislation, and will appreciate receiving notice of the new legislative measures passed by the states. In this way the National can act as a central bureau of information on the official status of public health nursing throughout the country.

We wish to add at this time two clauses to the list of state laws published in our May number, collected by James A. Tobey:

New Mexico

Laws of 1925, Chapter 73, Section 6.
This law permits the use of school funds for the employment of school nurses.

Tennessee

Code of 1926, Section 3111a1.
Visiting nurses may be employed by county health departments.

A correction is also made in the second paragraph of the May article: thirty-nine should read forty-one.

The Scope and Aim of a Mental Hygiene Program in a Public Health Nursing Association *

By Grace L. Anderson
Director, East Harlem Nursing and Health Service, New York

THE subject for consideration at this time is infinitely more complex than the title of this paper would imply. On the one side we have no uniformity in public health nursing but, rather, a variety of types of public health and social health agencies in which nursing may or may not be the predominating activity. The term "public health nurse" itself has no absolute connotation. The preparation for public health nursing, in its newer aspects, is still largely the responsibility of the agencies, official and voluntary, that depend upon the nurse to carry on their health activities. As the scope of public health work has broadened to include the building and preservation of health, as well as the control and prevention of disease, the demands made upon the nurse have increased far more rapidly than the opportunities for her professional preparation through post-graduate study. Our staff education programs, meager or elaborate as they may be, reflect not only the newer developments in public health and social work but the inadequacies of our basic professional and academic training.

The mental hygiene movement has not recognized in the nurse an agent qualified to serve directly in this campaign for the control and prevention of mental disease and the building of optimal mental health. When the psychiatrist came out from the mental disease hospital and began to look for the basic causes of mental disease and emotional maladjustments, he found that his professional preparation had not fitted him to meet, single-handed, the complex problems in human behavior that became ever more apparent. In order to project himself into the community, he had to depend upon an auxiliary worker who was capable of bringing to him the many facts about his patients that could be learned only through an intimate knowledge of environmental factors. It was not the public health nurse but the social worker whose professional equipment was more nearly adequate for the required task. Mental hygiene is not psychiatry alone but psychologized and socialized psychiatry. The psychiatric social worker has been evolved by the fusion of the techniques of social case work with those newer techniques that have been evolved by the psychiatrist, with the psychologist, as extra-psychiatric hospital functions.

The scope of mental hygiene, as outlined in the statement of purposes of the National Committee for Mental Hygiene, includes not only work "for the mentally disordered and those suffering from mental defect, but for all those who, through mental causes, are unable so to adjust themselves to their environment as to live *happy and efficient lives.*" The universality of the need for guidance in the principles of mental and emotional health has led to the characterization of the mental hygiene movement as "one of the most gigantic and romantic efforts of modern history." In the movement, educators, physicians, psycho-therapists of all types, social and legal workers, clergymen and all others interested in the fullest development of our human potentialities are banded together. Large business and mercantile establishments have recognized the money value of a mental hygiene service for their employees. The psychiatric surveys of prison populations is the basis of legislative program for the proper treatment of delinquents.

* Paper presented at Round Table on Mental Hygiene, Biennial Convention, Milwaukee, Wisconsin, June 12, 1930.

THE ROLE OF THE PUBLIC HEALTH NURSING ASSOCIATIONS

Public health nursing associations, in increasing numbers, are recognizing the need for the inclusion of "mental hygiene" in their health programs. With what forces, then, may we, as representatives of public health nursing associations of varying types, best ally ourselves in this latest assault upon the factors that militate against human fulfillment?

It must be obvious to all of us that the scope of any mental hygiene "program" that may be undertaken by a public health nursing association will be dependent upon such factors as the peculiar responsibilities of the specific agency that may be considering such a "program"; the stage of development that the particular community has reached in working out a general program for mental health; the professional and educational equipment of the staff; the type of preparation of the leader who may be secured to inaugurate the new program; and finally, the budget that is available. A brief consideration of certain of these factors may help to clarify our thinking at this time, although as Dr. Williams warns us, armchair thinking can never take the place of experimentation and an examination of the facts in the particular situation in which we find ourselves. Such experimentation in our field has been carried on for a very brief period indeed—so brief that we should hesitate to speak in terms of a "mental hygiene program" were it not for the fact that we know that what we are groping for is a rallying point for our energies and a desire to use what capabilities we may have in this but recently opened field of public health.

PREPARATION OF THE WORKER

Of all the factors noted, that one which will be most likely to determine the slant of any mental hygiene program that we may undertake is the preparation of the expert who heads up the special service. There is a right wing and a left wing among psychiatric workers. On the right are those who are mainly concerned with the recognition and treatment of mental disease and the mentally deficient. We have, in this one aspect of the mental hygiene movement, a major social problem. We are all familiar with the facts in relation to this vast problem. It may well be that nursing, which developed along with modern medicine, might ally itself with this special field of mental hygiene. It is for this branch of service, only, that the nursing schools have as yet provided a minimum of professional equipment. Psychiatric nursing, like tuberculosis nursing, might resolve itself into a case-finding, placement, and follow-up service of great value.

On the left wing, in the mental hygiene movement, we have those workers who believe that emotional health is of paramount importance and, furthermore, that our greatest concern should be for the "mental health, conceived in its larger sense—the healthy emotional development of those who are destined to become leaders of one kind or another, in the life of the community." If we secure a worker who has this outlook, and it is this group that has been responsible for the preparation of the "psychiatric social worker," it is quite probable that the major emphasis of our mental hygiene program will be placed upon the special problems of the workers who are responsible for the general health program since, as Dr. Williams asserts, "it is ourselves, and not our clients, that possess the greater potentiality for social harm." Our mental hygiene supervisor would have the same relationship to the work of the association and the staff as does the mental hygiene counselor in the university, the mercantile establishment, or other organization. The range of the problems that she would meet would include the personal emotional problems of the workers, their better educational and professional equipment for a fuller service, and the daily problems in human relationships encountered in the regular line of duty. To the extent, only, that the individual worker may be led to see her own strength and

weaknesses and their underlying causes will she be fitted to cope with the similar problems that she meets in her everyday tasks. We should look to the mental hygiene supervisor, also, for a study of the various nursing and health services in order to determine what public health nursing may contribute to mental hygiene knowledge through its peculiarly advantageous approach to family life.

A third type of program that may be developed by a nursing association is one that extends downward the methods of the child guidance clinic and the nursery school. Special workers who have secured their practical experience in either of these fields would be aware of the exceptional opportunity presented by the natural entry into the homes of very young children, not reached by other agencies. No one can measure what the influence of the nurse has been in the prevention of childhood maladjustments through her teaching in regard to correct habit formation in infancy. No better approach can be found by the health worker for effective guidance toward mental health than is offered by a child health program, particularly when this program includes the continuous supervision of the development of the child from conception through the so-called preschool years.

THE QUESTION OF FUNDS

In considering the scope of a mental hygiene program the funds available for this extension of service, or intensification of function, will be a determining factor. Mental hygiene work, whether it be case-finding, placement, and follow-up, staff counselling, child guidance, or a combination of these activities is time consuming and therefore expensive. Mental hygiene is intensely personal. The technique of the interview, when one is trying to absorb impressions in regard to family interactions, is quite opposite to that of the more or less didactic teaching of a health visit. Case histories and conferences require time. To be sure, we believe that this time will be well spent, but time and visit costs mount with the enrichment of the nursing program. If mental hygiene work is added to an already full nursing program, we should think in terms of increasing the nursing staff in proportion to the time that is given by the staff to the new service.

Finally, although the scope of a mental hygiene program in a public health nursing program will depend, as we have already stated, upon such factors as the association's general program, the capabilities of the staff, the community resources for the care of the mentally disabled and the treatment of maladjusted individuals, the type of leadership obtainable, the budget for the new service, et cetera, there is one factor that will be common to all of the experimental programs, namely, the need for the preparation of the staff. This preparation, as we have indicated, may take the form of specific practical training for a new service to be added to the nursing and health services already carried. It may be that mental hygiene will not take the form of an added service but that it will give a new method of approach to old problems. In either case, the mental hygiene supervisor will come to us as a teaching supervisor, one who like the specialists in nursing, nutrition, social case-work and teaching methods, will give of her special knowledge and skill to the nursing staff in the interest of a fuller and richer community service.

The paper on *Mental Health* presented by Dr. E. P. Lewis of Toronto will be published in the September number of the magazine, as will also Dr. Charles H. Keene's paper on *School Health*.

Mental Health in Boston *

By Marie Knowles
Supervisor, Community Health Association, Boston, Mass.

FOUR years ago "mental health" as a part of the service of the Boston Community Health Association was in its infancy, and the nurses had very little idea of what it was all about. We knew that our newly appointed supervisor had been in charge of the Social Service Department of a mental hospital, and so we supposed that she might be able to help us secure care for the mentally defective and mentally diseased. As to what else she could do we were very vague, and I think a good many of us wondered if it was really safe to ask her to visit our families. We were not at all sure that she would not hurt our relationship with them.

We had frequently, in our work, come in contact with people of low mentality. When the deficiency was obvious enough, we recognized it and were apt to feel, impatiently, that such people ought to be in institutions. But often the difficulty was not readily detected, and we wasted much time and energy in trying to obtain from mothers of this type what they could not possibly give.

Since 1926 our attitude has changed greatly. We know that a good many very limited people can, by patient home teaching and supervision, be made acceptable and useful. We realize that if we are to be successful in helping mothers, we must have some understanding of their mental ability, and couch our teaching in terms which will have significance for them.

In the past we, in common with other health workers, had tried to make plans for this or that family, only to find ourselves constantly running against a stone wall. We were apt to go away, dismissing the family with some irritation as "uncoöperative."

Now we have learned that probably we ourselves are at fault if we are unable to make a good contact, and we go away resolved to analyze the situation and discover why we were unsuccessful and try another method the next time.

The following stories will illustrate this:

Mrs. J. never admitted the nurses to her home. The reason she gave was that she did not intend having anyone come in and tell her how to run things. She prided herself on the fact that none of her children had ever been to a clinic or had a doctor.

One day we received an emergency call from Mrs. J.'s neighbor who said that she thought the baby was dying and the parents had not called a doctor. When the nurse arrived, she saw no time could be lost and took the baby herself to a nearby hospital where it was pronounced dead on arrival. The cause of death was malnutrition, rickets and scurvy. On discussing the situation with the parents later, she found that neither one had the slightest idea the baby was ill. Their grief was genuine and they begged the nurse to believe that they had loved their baby and did not know that a patent food and water was not an adequate diet for it.

On investigation it was found that neither parent had the slightest idea of the proper diet for little children. As intensive work was needed, we asked one of our nutrition workers to take up the case. She and the nurse, realizing that the mother's mentality was low, decided to work through the father until the more gradual teaching of the mother could be accomplished. After the first interview Mr. J. ordered two quarts of milk to be delivered daily; detailed food lists were made out for him, which he used with considerable intelligence. To make the mother feel that we were really interested in her welfare and that of the children required time and patience, however, for she was suspicious and unfriendly. Because we understood her limitations, we had the courage to continue.

Now she is doing a much better job as a mother. She watches the children more closely, is able to detect symptoms of physical disorder, and is willing to call the doctor when he is needed. The oldest boy has had

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his tonsils out and the mother is beginning to think about having the bow-legs of the baby corrected. She is planning the days far more adequately than she was able to do before.

Mrs. G. is a staid serious-minded woman, 34 years old, who has become very self-centered as she is alone a great deal, has few friends and no outside interests. When we first knew her she was beginning her second pregnancy; she was nervous, depressed, and apprehensive, as her first baby was still-born.

The nurse urged her to put herself immediately under the care of a doctor in whom she had confidence and then leave her worries with him. She also invited Mrs. G. to our weekly Mothers' Club at the district office. Mrs. G. was immediately interested; she attended very regularly, and at the suggestion of the nurse came to the office frequently when she felt the need of reassurance and encouragement. Mrs. G. improved greatly, came through her delivery very well, and had a beautiful baby.

When the baby was sixteen days old, however, Mrs. G. felt weak and miserable, as do most mothers during the first weeks after confinement, and began to be obsessed with the idea that she had tuberculosis. In addition she was absolutely overwhelmed with the care of the new baby and was unable to organize her household at all. It seemed wise for us to plan to have the baby bathed daily and to get a woman to help with the housework until an orderly routine could be established.

This plan seemed to be just what Mrs. G. needed. Whereas at first she found herself at the end of the day exhausted, baby not bathed, washing not done, beds not made, and entire household in a turmoil, she had been helped to bring order out of chaos. She had accomplished more than she had dreamed she could and experienced a decided feeling of superiority which follows deeds well done.

This patient will probably always require help and guidance whenever a crisis arises, but we feel we did preventive work as we were able to tide the patient over the acute period and avoid a serious break; we left the patient with a feeling of security, and we helped her see that she must control herself in order that her baby may be normal, calm, and free from nervousness.

Mr. W., a man of 58 years, had been all his life self-respecting and hard-working, getting along without aid of any kind. He had recently married for the third time a widow with whom life was fairly comfortable. His economic efficiency was lowering as was his physical capacity.

In January he left his work and has never returned. His wife stated that he was "lazy and unwilling." She came to our district office for advice and as her story indicated financial need only, she was referred with a note to the Family Welfare Society. Their visitor went to the home, decided that the case was not one for their agency and referred him to the Department of Public Welfare.

Mr. W. went to the Department of Public Welfare with a note written by the Family Welfare visitor. He had a long wait and became so upset that by the time his turn came for an interview he could not even state the reason for his coming. He was labelled as just "dumb." He was sent home without assistance of any kind.

On his return, nagging and quarrelling began all over again. The police were called in, also the probation officer, but no one recognized the need of medical advice. Finally in desperation Mrs. W. again returned to our district office. Her story made the supervisor feel that the man had a mental illness, and accompanied by the mental hygiene worker, our first home visit was made.

There was found a pathetic little old man probably years older than the age given. He showed definite mental symptoms which warranted immediate attention. The case was returned to the Family Welfare worker and a request made for their consultant psychiatrist or city alienist to visit. This plan was carried out and the man immediately committed to a state hospital.

The man needed hospitalization six months before, and if this had been realized much unhappiness, strained feeling and bitterness could have been avoided. There will now be needed considerable guidance and educational work to keep the wife interested in her husband and to make her realize that this has all been illness, not laziness, on her husband's part.

These cases cited show what we have tried to do, and the results which have been accomplished. We feel that with the help and guidance of our mental health supervisors, we are seeing problems which we never recognized before and we have a Mental Hygiene point of view in every family we visit. Our nurses are seeking psychiatric advice for themselves more frequently, realizing that they can be of little assistance to their patients unless their own lives are well adjusted. Because our own mental health is better we are able to bring more pleasure into the lives of those whom we visit, and are much more nearly approaching the goal of all living—happiness.

How the Official Health Organization Can Aid the Nurse in Industry *

By W. W. Bauer, M.D., Fellow A.P.H.A.
Commissioner of Health, Racine, Wisconsin

THE inherent selfishness of human nature has made me think more often of what the industrial nurse can do for me as a health official, than of what the health department can do for her. This assignment has made me think less selfishly, and I shall benefit from it.

THE INDUSTRIAL NURSE A PUBLIC HEALTH NURSE

The first and most important thing which the public health department can and must do for the industrial nurse is to recognize her place in the public health program. I regret to say that there are industrial nurses who have not realized that they are public health nurses, in the broader interpretation. They have not recognized this because we—public health officials—have not recognized them. We have allowed them to become engrossed in the detail of their daily work, and so to miss the larger and wider vistas of service before them. We cannot expect management, which is intent upon successful operation of its business, to point out the opportunities for service which lie at the door of every industrial health nurse. That is not their job; it is our job.

Recognition of the place of the industrial nurse among public health workers means departure from the narrow conception of this nurse as a roller of bandages, a purveyor of little pink pills, a swabber of iodine or its latest substitute. It means widening the outlook, making something more of her than a guardian of the payroll through accident first-aid service, or a watchdog of the employers' liability costs through the same channels. It does not mean abandoning these, for she has given and must continue to give proper regard to the obligations which she owes management. It does mean adding other functions.

Whether she wills it or not, the industrial nurse becomes a health educator; either a good one or a bad one. The people in the shop or the office or the store come to her for advice. If she knows her job she will welcome them, and will strive to fit herself so that she may be a safe source of information. In this, the public health agency can help her. Let us see how.

ASSISTANCE FROM THE PUBLIC HEALTH AGENCY

A working mother anxiously approaches the nurse, and says that she has heard of scarlet fever in a certain school district. Is the rumor based on fact? If so, how can her children be protected? The industrial nurse should feel that all she needs to do is to call the health department and ask to have a nurse from the department call on this mother and point out to her what she can do to help protect her children. Or perhaps the health department has supplied her with literature which fills the need without the telephone call. The mechanics of the service are unimportant. The essential thing is that the wheels of the official health machine ought to swing easily into motion upon the touch of the starting button, which is the request from the industrial nurse, and there ought to be no creakings and groanings to indicate the lack of that supreme lubricant, coöperative good feeling.

RESOURCES OF THE HEALTH DEPARTMENT AT THE COMMAND OF INDUSTRY

Management, we will suppose, says to the nurse, "Why are the arms of

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our men on certain jobs subject to skin diseases of one kind or another?"

That is a question for a physician, obviously, but lay management does not always discriminate, and if the nurse can answer that question she will have boosted her stock with the firm and so enlarged her sphere of usefulness. She ought to be able to go to a friendly health officer who will turn with her to the health department library of special books which do not fall within the scope of the public library, and find the answer to that question. After all, the industry is a payer of taxes, and ought, through the nurse, to have all the resources of the public department at its command on questions of health.

Another way in which the public department can be and ought to be of service to the industrial nurse is by offering opportunities for keeping up to date on health matters. This impresses me as of particular importance in the smaller cities, because it is in one of these I am now working. They are remote from the educational centers, if not actually in distance, at least in paucity of opportunity for workers to see and hear the new and interesting things developing in that rich field of endeavor, the guarding of the public health. Films may be offered showing how biological products are made. Demonstrators or lecturers may be available. Health education stunts are arranged. The health officer arranges these events. Does he always share them as he should? Does the industrial nurse receive an invitation to see them, or to arrange a showing in her plant for those who may be interested and benefited? And—it is a fair question, does the nurse always respond to opportunities when the health officer is generous?

SHARING STAFF ACTIVITIES

The public health department can also be of service to the industrial nurse if, when organizing institutes and other staff education projects, the industrial nurses are invited to attend and to participate. In Racine last year, we had an institute, which extended well into this year, because we did not concentrate the program as usual into a day or two, but spread it over 18 weeks. To this the industrial nurses were invited, and they responded in gratifying numbers. Several did more, they participated, thus making the benefit mutual.

Another way in which the public health department can be of service to industrial nursing as a whole, is to be liberal in guiding well-prepared public health nurses into favorable industrial positions. From the standpoint of the health officer, I assure you that there is no pleasure in receiving notice from a local industry that a certain nurse in the health department is desired for an industrial position. There are two nurses at this time, serving in industrial jobs in Racine, who received their public health experience in the health department. We were not glad to see them go. Of course they would have gone anyway, because industry has money to buy what it wants, and cities do not always have. But we sped them on their way, and they have been good friends of ours since, and we have been good friends of theirs, and everybody concerned has profited.

The health department can enlarge the opportunities of the industrial nurse for service by offering her participation in the programs of health betterment and service which are planned for the community at large. Is vaccination for smallpox being stressed? Would not the industrial nurse serve her industry and its people by offering these opportunities to them? Are physical examinations being offered to preschool children? Is diphtheria prevention the health message of the hour? Are we fighting for early diagnosis of tuberculosis? Is cancer in the limelight? Whatever the health program may be emphasizing at the moment, would not the industrial nurse be definitely enhancing the value of her service by interesting herself in it? Would not the health officer, in strengthening her, enlarging her usefulness to industry, be serving not only

the community but the industrial nurse in a manner well worth while?

These are the definite things which occur to me that the health department can do to help the industrial nurse. Undoubtedly there are others. It is much easier to point out what should be done than to do it. We are doing some of these things, but we are doing none of them as well as they ought to be done.

COMPETITION THE DEATH OF HEALTH WORK

In closing, let me point out, that the development of a strong and aggressive health program in the community is a help to the industrial nurse whether she knows it or not. The awakening of a health consciousness in the community strengthens all health agencies in that community. Therefore any agency which strengthens itself strengthens all the others as long as it keeps a coöperative attitude. Health workers have learned that competition, reputed to be the life of trade, is the death of social work, including health work. The health department can and must serve the industrial nurse by building up a strong health service in the community, and especially a strong health education service. The industrial nurse will find that working with men whose wives are attending baby clinics, whose families listen to radio health talks and read health literature, and whose children have had physical examinations and courses in hygiene, is a different matter from working with those whose families have experienced none of these privileges of a well-developed plan of health service.

Like everything else that succeeds, it is a matter of coöperation. The health officer cannot serve the industrial nurse without benefiting his own organization, and the industrial nurse, on the other hand, cannot contribute to the success of the general health program without strengthening her own position. Neither can ignore the other, or worse, obstruct the other, without weakening himself or herself.

STAFF NURSES AT THE BIENNIAL CONVENTION

Staff nurses attending the Convention had a special program all their own as well as sharing generously in the N.O.P.H.N. general program. A group "get-acquainted" meeting was held Monday afternoon following registration. A round table held at the same time as the executive, supervisors and board members were meeting, was largely attended and included the following addresses:

Presiding: Mabel Moodie, R.N., Public Health Nursing Association of Pittsburgh, Pennsylvania.

Staff Councils—Are They of Value. Bertha Houston, R.N., Department of Health, Detroit, Michigan.

How Can Records Be Made More Attractive and Useful. Grace Dettman, R.N., Visiting Nurse Association, St. Louis, Missouri.

Evaluation of Staff Meeting Reports and Programs. Rowena Harrison, R.N., Public Health Nursing Association, Indianapolis, Indiana.

The Staff Nurse's Responsibility for Self Education. Helen Schwaller, R.N., Visiting Nurse Association, Milwaukee, Wisconsin.

Communicable Disease Control *

In Relation to Public Health Nursing

By John T. Sippy, M.D.

District Health Officer, San Joaquin Local Health District, Stockton, California

MY topic reminds me of that story of the old physician noted for his brusque manners and methods. Called to attend the baby in one of these newly rich families, when the infant was slightly ailing, he prescribed castor oil. "But, doctor," protested the mother, "castor oil is such an old fashioned remedy." "Madam," he replied, "babies are old fashioned things."

At the outset of a public health career, with unlimited faith that the laboratory could and would offer a remedy for everything infectious and contagious, I believed that communicable disease would shortly go the way of other things prehistoric. I imagine, too, that, like many other enthusiastic neophytes, I did my full share in relating and promising things that were not and cannot be so. Some two decades of much futile effort has been somewhat disillusioning.

Of course, preventive medicine has had its triumphs, and when we review the reduction of certain insect and sewage-borne infections, some of them to the vanishing point, we may well feel proud of public health accomplishment. On closer analysis, we find that the measures instituted for the control of these mentioned diseases have achieved success only in so far as they have been instituted by group action, and are not daily dependent upon individual operation or choice. Our municipal water purification and sewage disposal systems, our food and sanitary inspection departments, and our mosquito abatement and reclamation projects protect us whether or not we give them thought. But in those diseases dependent upon human vehicles, which can be controlled only by individual acts and exercise of discretion, we deal with a different problem and, since human nature is slow to change, for the most part unsuccessfully.

Control through individual effort

Success in the control of this group of infections, largely the respiratory type, depends upon individual coöperation. Securing that means individual solicitation and instruction and regiments of instructors. Health officers may command and direct, but just as every line of battle must have its shock troops, so we must look to public health nurses to comprise the soldier units of these regiments.

Of course, there are soldiers who enlist because army life gives opportunity to wear a uniform or provides a steady commissary. The majority enlist from motives of patriotism and loyalty to a cause. Let us believe that these latter constitute 100 per cent of the public health nursing ranks. And believe it or not, every public health nurse must be a communicable disease nurse. If she does not believe it, she has failed to recognize her most formidable enemy beside which all other pathologic problems are only minor allies.

A careful plan of attack

Success in battles is the result of careful organization and plans. In our attack on existing communicable disease we are expected to follow certain rules of quarantine and isolation. Sometimes we are importuned or feel tempted to disregard certain of these, and, indeed, some of them may seem

* Paper presented at the General Session of the National Organization for Public Health Nursing Biennial Convention, Milwaukee, Wis., June 11, 1930.

irrational. Nevertheless, failure to observe them, even to minute technicalities, gives encouragement to the unconvinced or the belligerent.

In one state, for instance, no quarantine is established without the posting of a red or yellow cloth or card not less than twelve inches square. A violator of quarantine on being brought into court established the fact that the health officer through his nurse deputy had posted a white placard ten by fourteen inches, and was therefore acquitted.

In another state it is specified that the quarantine placard must be yellow in color, because the state realtors' association contended that "For Sale" and "For Rent" signs are printed in red and white, and yellow was essential to avoid confusion.

Periods of quarantine vary. Variance in scarlet fever, for instance, may be from twenty-one to forty-two days. In some states wage earners may go and come from quarantined premises; in others they are prohibited. In one or two northwestern states no quarantine is imposed in smallpox. In these it is contended that persons who do not wish to have smallpox may avoid it by successful vaccination, and therefore it is unfair to impose the expense of quarantine upon local communities just because a few persons do not wish to be vaccinated. This attitude is in full keeping with the Federal Constitution, which protects the citizen in his inalienable right to have or not to have smallpox instead of to be or not to be vaccinated.

KNOW THE LAW!

Sometimes municipal ordinances supplement and are more stringent than state laws. No matter where he or she may roam, the first duty of the public health worker is to know the law and regulations under which one must operate. Fortunately, in most instances the courts and public opinion are liberal in interpretation of public health powers and intent, and it is the unusual violator who has the wit to take advantage of technicalities. But no worker can afford the humiliation of exposed ignorance.

Every army must have its intelligence or signal service. This is true in the campaign against communicable disease. Maine may seem far distant from California, but in these days of air transportation it is but a day. Our federal, state and local boards of health furnish frequent bulletins on disease incidence. Their contents may seem dry and uninteresting, but to the alert public health worker they reflect menace. They are couriers who keep us constantly advised of the enemy's positions, his movements, and his rapidity of advance. By charts, mental or actual, we can map our battle lines, and the successful worker will watch for and heed these couriers.

Constant vigilance against attack is the price of security. Every good soldier is always on guard against surprise. The public health worker who, because of other seemingly important duties, delays or postpones immediate investigation of the first suspicion of contagion may cause unlimited damage.

RECOGNITION OF THE ENEMY

We must be able to recognize our enemy and know his manner of attack. I realize that there are those who contend that the public health nurse must not diagnose. Technically she is not charged with that responsibility. But for the most part I can see nothing so mysterious in the symptomatology of the commoner communicable diseases beyond the comprehension of the well trained and observing public health nurse. Certainly if such an one who has been taught, as good public health nurses are taught, that a definite train of symptoms is peculiar to a certain disease, fails to report her diagnostic suspicion or, in the absence of physician or health officer, fails to establish the prescribed defense, it is a sad reflection on her intelligence and the training which medical men have given her.

Fortunately for the public, and largely due to higher standards of education of the public health nurse, the

belief that she is not supposed to do some thinking for herself is antiquated. We may also regard as antiquated the public health nurse who does not know of the incubation, the duration, and manner or modes of infection of the common communicable diseases.

Every good strategist keeps informed not only of the enemy's strength and movements, but of his own vulnerability. Only non-immunes succumb to infection. Fortunately, in most diseases, one attack provides immunity. Or, as in the case of smallpox, diphtheria, or typhoid fever, artificial immunity may be produced. A census of these immunes and susceptibles forms a fairly exact estimate of the strength or weakness of a community in the event of communicable disease invasion.

A number of years ago, Dr. A. J. Chesley, now State Health Officer of Minnesota, described a method of making such a census. It seemed so feasible that, when our Local Health District was organized, we thought we would try it. It has now been in use seven years and has proven practicable.

CENSUS OF IMMUNES AND SUSCEPTIBLES

Our district covers an area of 1,500 square miles and includes four incorporated cities and a large rural area. It has a population of 110,000, of which 20,000 are in schools. This area is covered by twelve field nurses, each given a certain district. There is, of course, ample medical and laboratory assistance. The nursing service, with exception of bedside care, is generalized and includes school nursing in public, parochial, and private schools.

Some contend that school nursing service is something to be set apart from other types. It has been our own experience that the school affords the most effective opportunity for family and home contacts and, therefore, entry for all other health instruction. The combination of school nursing with that of communicable disease, of infant and pre-school, of pre-natal, of tuberculosis and other work, is not at all illogical, especially where the nurse is limited to a district in which she becomes intimately acquainted with every family. In fact, it is decidedly advantageous, although I must admit it requires nurses of broad training and liberal experience.

When a child enters school, there is filed for him a communicable disease and immunization history card. Preferably the information is obtained from the mother, although since so many children have been under our observation since birth, much of this is available from our infancy and preschool records. It will also be available even after the child has grown to adult life, as will his physical examination record. I like to think that a health department should have a physical inventory of every citizen, and perhaps some of you, as an example, will evolve a demonstration of this in your community.

At the beginning of each school year, the teacher in each room lists on a sheet the names of all children in alphabetical order. In columns opposite each name is listed the diseases which each child has had, and those diseases against which he has been artificially immunized. This gives us our school tables of immunes and susceptibles and we can estimate approximately how far any outbreak of contagion may progress.

HOW IT WORKS WITH MEASLES

For instance, a case of measles, a disease, for reasons with which you are familiar, most difficult to control, develops in a room of thirty children. By reference we find that twenty of these are said to have had measles. Since second attacks are rare and since the margin of error in our information is small, we give attention only to the ten remaining children.

If this is the first introduction of infection into the community, we permit these to attend school until the eighth day, and then carefully isolate them at home. Those who develop the disease will do so in isolation and not expose others. Those who do not

become ill are permitted to return to school after the fourteenth day. We have thus been able to prevent a number of threatened outbreaks.

If, however, the disease is generally prevalent on all sides of us and there have occurred many exposures outside of school, we cannot create too many school absentees. In such event, a "watch" or "warning" letter is sent to the mother of each of the ten non-immunes, advising her of the date of exposure, of the dates when she may expect her child to develop symptoms, of the nature of these symptoms, and requesting her to isolate the child upon appearance of the first signs. She is also advised to put the sick child to bed for one week, to call a physician and to report the illness immediately to the health department.

Of course, some mothers ignore, or even cannot read these letters, and the teacher and nurse must supplement this vigilance by observation, by taking temperatures and by noting the buccal membranes for "Koplik's spots," so as to catch beginning cases before they do damage. We do occasionally find a teacher whose fetish is attendance and who still gambles that an ailing susceptible is not developing measles. Repeated bitter lessons and still heavier penalties in attendance losses are making these teachers more and more obsolete.

It is especially gratifying to find the large number of mothers who do cooperate in every particular and that, furthermore, complications and deaths are reduced. Our 1927 outbreak, although we registered nine thousand non-immunes, was characterized by 3,400 cases and three deaths. In this year's outbreak beginning eight months ago, and again we have nine thousand non-immunes, only one fatality (a child of a Mexican mother unable to read) has occurred in 1,200 cases.

This procedure is purely a field method. It does not purport to be wholly preventive, but only obstructive, and our experience indicates that obstruction and prolongation of the outbreak reduces virulence, complications and deaths; and perhaps that, after all, is more desirable than complete prevention. Seemingly too it decreases the aggregate number of cases, for repeatedly in different communities the total has never exceeded forty per cent of registered non-immunes. We can predict with considerable accuracy the peak and end of the wave, and thus enable our nursing staff to plan work accordingly.

DIRECTED EDUCATION

In smallpox and diphtheria, vigilance is centered upon the non-immunized, for, as I have stated, immunization histories are recorded as well as previous disease attacks. The occurrence of cases lends double emphasis to methods by which immunity can be created, and with our census we are enabled to direct our education and solicitation where it is specifically needed and not in hit or miss fashion.

It is surprising what results can be obtained from procrastinating parents by a letter of warning giving exact exposure, together with an offer of free vaccination if the family is not disposed to go to the family physician. Even though we are located in a state where vaccination of children is not compulsory and reputed to be most unpopular, seventy-five per cent of our population has been vaccinated against smallpox, and eighty-two per cent of children in grades one to five (*i.e.*, children from six to twelve years) has been immunized against diphtheria. I may say, of course, that our immunization campaigns are not limited to school children, for through our infant and pre-school conferences held regularly throughout the year in all of our health centers, continuous education is carried on. We have now reached a near maximum of vaccinations and immunizations each year. By that, I mean a number equal to double the number of births. This apparently accounts for all new babies plus the usual turn-over in population.

Of course, we are never satisfied and the fact that our diphtheria death rate in seven years has fallen from fifty-one to less than one per hundred thousand population gives us no false complacency.

I might relate methods employed in other infections, some not so fortunately. Mumps with its uncertain incubation and whooping cough with its uncertainty of diagnosis in its early stages, are not so ideally amenable to control. Still they would be much less so if it were not for our knowledge of susceptibles.

Perhaps the disease census method might not be practicable in congested metropolitan areas, but the nurse in smaller cities and rural communities will find it reduces travel, saves time and conserves her temper by eliminating many home visits and many arguments as to whether this or that child has or has not had a prevailing infection. At the beginning of the school year and before contagion and exposure develops, mothers' memories are always more accurate than when children are faced with school exclusion.

PREPAREDNESS

The best warfare maxim is that of preparedness. An unbarricaded position invites invasion. A population which has not been taught to exercise discretion in the transmission of human secretions and excretions, or how to build up immunity, is defenseless against infection. Ignorant peoples are easily conquered. The good soldier in the campaign against communicable disease must therefore be an educator, and as I have said public health nurses constitute our first line troops in this rôle.

I am wondering, however, if she always fully appreciates that responsibility or the need of her own thorough preparedness in every detail. Mothers ask—Is diphtheria preventable? If there is a protective method, is it a safe method? At what age should my child secure this protection? Is it always infallible, or does it sometimes fail to give immunity? What is the percentage of failure? When should I have my child vaccinated against smallpox? Should it be given on the leg, and if not, why not? If one does not get a "take," is it because he is naturally immune?

It may seem proper to answer these by generalities or to refer the anxious mother to the physician, but the nurse who follows either course will accomplish little. The nurse is the mother's confidant and if she cannot provide explicit answers she loses that confidence.

There is much we do not know concerning immunity and its production, but there are a few facts which are fairly well determined. At least, the nurse can learn these and translate them into simple language which mothers can understand. It behooves all public health workers to restrict advice to those few measures which have been definitely proven, and to avoid recommending those things which are debatable or still in experimental stages. The field of preventive medicine is littered with the debris of many false hopes. My own past activities in promoting public health claims and fads which have been discredited and which only impeded progress have taught me much conservatism, if not skepticism.

ATTITUDE OF PERSONAL RESPONSIBILITY

No educational program is complete which does not have for its objective the inculcation of personal responsibility for disease prevention. But all too frequently our questionable refinement of manners permits us to tolerate the mother who with utmost indifference permits her disease-afflicted children to roam at large and infect the neighborhood and school. It is not enough to teach her that this is extremely bad mannered, but the neighbors must be taught to punish her and hers with social ostracism.

The nurse must be able to instill not only conscientiousness and regard for the rights of others, but recognition that all sore throats, colds, fevers and

rashes require isolation until they prove to be non-communicable, for in children few of them are. Helpfulness inspires confidences and when the vast majority of mothers regard nursing visits as first aids instead of intrusions, the problem of disease control is well on its way to solution.

It really seems unnecessary to emphasize the teaching of sanitation and personal hygiene, for that is the very basis of public health nursing. Health habits are beginning to be regarded as good etiquette, and aesthetics, if not a desire to prevent transmission of infection, are aiding us in the war on communicable disease. So let us continue to preach that good manners constitute health protection.

To summarize, communicable disease control involves the following principles:

First, knowledge of legal requirements under which one must operate.

Second, constant vigilance and study of the geographical distribution of disease.

Third, ability to recognize common infections and epidemiological principles governing the transmission.

Fourth, knowledge of community susceptibility.

Fifth, constant improvement of defense by known methods of artificial immunization and by education in personal hygiene.

NEW NATIONAL OFFICERS

THE AMERICAN NURSES ASSOCIATION

President—Elnora E. Thomson.

First Vice-President—Jane Van de Vrede.

Second Vice-President—Mabel Dunlap.

Treasurer—Jessie E. Catton.

Secretary—Susan C. Francis.

Directors:
Julia C. Stimson.
Adda Eldredge.
Genevieve Clifford.

NATIONAL LEAGUE OF NURSING EDUCATION

President—Elizabeth C. Burgess.

First Vice-President—Elsie M. Lawler.

Second Vice-President—Anna D. Wolf.

Treasurer—Marian Rottman.

Secretary—Stella Goostray.

Directors for 1930–32:
Nellie X. Hawkinson.
Carrie M. Hall.
Gladys Sellew.
Claribel A. Wheeler.
Mary M. Roberts, ex-officio.

IN MEMORY OF MISS CLAYTON

On the eve of the Convention a memorial service for Miss S. Lillian Clayton was held in St. Paul's church in Milwaukee, Rev. Holmes Whitmore, rector of the church, conducting the service. Dean Annie W. Goodrich of the Yale School of Nursing presented an interpretation of Miss Clayton's life which was a beautiful tribute to a great leader.

The posthumous award of the Saunders Medal to Miss Clayton for her "distinguished service" to the profession, took place on Thursday evening. Dr. Joseph C. Doane of Philadelphia presented the medal which was received for her school by Miss Constance White, president of the Student Council of the School of Nursing, Philadelphia General Hospital.

Hourly Nursing from the Visiting Nurse Association Viewpoint *

By Ruth Hubbard
Director, Visiting Nurse Society, Philadelphia, Pa.

HOURLY nursing as we understand it today has been practiced by individual nurses throughout the country for a number of years. It was first inaugurated in Visiting Nurse Association programs soon after the World War when a shortage of private duty nurses presented a problem in the care of the so-called pay patient in his home. This need, together with the growing realization on the part of Visiting Nurse Associations that their services should be available for every member of the community and not only for special groups, has crystallized in the incorporation of hourly services in many organizations during the last twelve years.

The patient who needed a part-time nursing service and lived on Park Avenue had as much right to it as his neighbor on First Avenue. The problem was, could this service be satisfactorily rendered by visiting nurses? After much careful study and with the approval of local medical societies Visiting Nurse Associations throughout the country have entered upon this widened service. It has grown—slowly, in most communities, but steadily and surely. As a result, it is now no uncommon thing to have an out of town visitor call the Visiting Nurse Association, present a written order for treatment from her physician, and receive the local hourly service. The service has become gradually more widely known and adopted by residents in the community.

In 1929 twenty-nine organizations sent reports to the National Organization for Public Health Nursing of the hourly appointment services they were including in their programs. Organizations ranged in size from staffs of six nurses to one hundred and eighty nurses, and were located in cities scattered through the United States.

Three methods of administration seem to have been developed:

The service is carried by a group of specialized nurses within the organization.

It has been undertaken in conjunction with another group, as for instance a nurses' registry.

It has been generalized throughout the staff of the organization.

The subject before us for consideration this morning is the provision of nursing service for every member of the community. Let us analyze the advantages to the patient, the physician, and the Visiting Nurse Association, of the inclusion of an appointment service in a Visiting Nurse Association program. To the patient, who represents the community, the hourly service offered by a Visiting Nurse Association offers four distinct advantages.

Advantages to the Patient

He may have service which is maintained at a high standard, rendered entirely under the direction of a physician by a member of a staff trained to utilize time efficiently, and accustomed to working in a group under supervision. The nurse who serves him is used to constant adjustment to home situations. She can improvise ways and means of carrying out orders without causing undue disturbance in the family. The visiting nurse thinks in terms of the health of the patient and his family. Not infrequently she is able to give teaching service in the homes of her hourly patients as she does in the homes of her free or part pay patients. Knowledge and financial

* Paper presented at the joint session of the National Nursing Organizations, Biennial Convention, Milwaukee, Wis., June 10, 1930.

security do not always go hand in hand. The visiting nurse with her broad vision of community health not only sees her opportunity but is equipped to make use of it in an acceptable manner.

This service can be rendered regularly day after day over an indefinite period of time at the same hour. The cost of the service, while higher than that for the organization's regular visits, will not be as great as the same service rendered by a group doing only one kind of nursing. This is true largely for three reasons:

The visiting nurse has a limited district and therefore spends less time in travel than does the private nurse carrying hourly patients.

The visiting nurse can utilize to advantage the time between hourly appointments by caring for other patients in her district. A well planned day can be built around hourly appointments, eliminating to a large extent waste time and energy.

The visiting nurse is on a regular salary basis and is not dependent upon periods of extensive community illness for her yearly income. The fluctuations of hourly work by season and the tendency which such cases have to peak in certain districts can be levelled more easily in a generalized city-wide program than in a specialized hourly piece of work for two reasons. There are always patients to be seen in other parts of the district by the staff nurse whose patients go away, and a nurse from a neighboring district can help in an emergency with less disturbance to the day's plan than when assistance has to be secured from a distant part of the city.

OTHER ADVANTAGES

The physician in using a Visiting Nurse Association hourly service knows that his patients will receive interested nursing care of a uniformly high standard; that his orders will be promptly carried out; that he will be notified at once of changes in the patient's condition; that the patient who needs nursing care once a day or once a week only will receive it with the same regularity as the patient needing the constant attendance of a nurse; that this service will be available upon the same plane of interested service for his private patients as it long has been for his dispensary patients.

The outstanding advantage of this service to a Visiting Nurse Association is that the organization is enabled by the development of such a program to serve the entire community increasingly. This widened function of visiting nurses has been accepted as an objective for some years. But ways of achieving it have remained to be developed. The hourly service opens many doors formerly closed and challenges the nurse to reach the privileged half of society in the same effective way that she has been serving the less privileged group for nearly fifty years.

DIFFICULTIES

Difficulties of course present themselves in the development of any such involved service. With hourly work a major one is encountered in the formation of a policy in reference to types of cases to be accepted. The administration of the service so that the number of nurses visiting one patient shall not be excessive also constitutes a problem.

The patient needing general nursing care daily; a special treatment at regular intervals; the chronic patient; the case needing assistance at a minor operation; the seriously ill patient who needs care during her special nurse's time off; are types which lend themselves readily to the Visiting Nurse Association hourly service. The mother who wishes a nurse to spend an afternoon with her baby while she shops, or the family which desires a companion for a chronic invalid at certain intervals cannot so easily be carried. The organization must always plan in terms of the relative needs of the entire community, and in making its policy decisions the less imperative demands may be eliminated so that the others can be met.

In any case of long duration rotation of nurses must be expected. We accept it in the hospital and the home is subject to similar adjustments. Naturally this is difficult for the patient, but usually the number of different nurses visiting one patient, even for a long time, can be kept as low as three with careful planning.

One problem which frequently confronts the hourly service in a Visiting

Nurse Association is presented by the patient who does not understand why a doctor must be in attendance and give an order before the nurse can administer a treatment.

PUBLICITY

In most organizations the problem of how best to make the service known has been a constant one. Initial publicity, largely through circularizing the physicians, is always undertaken. Usually a plan for repeated publicity at intervals seems to bring the most satisfactory results. The population of any community changes and a single circularization of apartments, hotels, and club groups is not sufficient. A number of Visiting Nurse Associations report that the slow growth of their services is a matter of concern to them. Perhaps we tend in public health to expect from others the intimate knowledge of our work which we possess. American advertising is founded upon the principle that the public needs to be reminded frequently what its wants are. Without doubt successful application can be made of this principle in developing hourly services.

PHILADELPHIA'S EXPERIENCE

Joint hourly services between Visiting Nurse Associations and registry groups have been satisfactorily developed in several large cities. A few Visiting Nurse Associations have developed their services with a specialized staff using the nurse for delivery service or limited district work between hourly calls. By far the greater number of organizations have worked out the plan on an entirely generalized basis. This has been the case in Philadelphia.

The hourly service in the Visiting Nurse Society of Philadelphia was undertaken in 1919 and has developed steadily, though not rapidly, since that time. From the beginning it has been completely generalized, the calls being answered by each nurse in her own district. When the service was started six nurses were added to the staff to absorb the work and as it has grown the staff has been increased to carry it. The service is available from 8 A.M. to 8:30 P.M. throughout the week, Sunday and holiday calls being answered in accordance with the need of the patient as is the care with the other patients. This phase of the program has not been developed at the expense of any other work. All adjustments are made in consideration of the needs of the patients regardless of type of fee involved. Evening hourly appointments are not common, but are carried whenever necessary and of course involve provision of make-up time for the nurse. Consequently the expense is greater. This rather generally limits the demand for evening service. The patient may have two visits during the day, but the nurse may not remain more than four hours at one time.

The service has paid for itself, the charge being based upon the cost of a regular visit with the necessary additional charge for the appointment element. In 1920 4,752.5 hours were spent for 355 patients in 4,112 visits. In 1929 a total of 5,879 hours were spent for 696 patients in 5,645 visits. Our service is now ten years old. Last year we reached twice as many patients as we did in 1920 and the income from patients was three times as great as in 1919.

CONCLUSIONS

In conclusion, it appears (to some of us) that the hourly service can be successfully incorporated in a Visiting Nurse Association service as a part of of the plan for community nursing service for three reasons:

It enables Visiting Nurse Associations to reach all members of the community alike in rendering nursing and health service.

It assures the physician of a regular service for his patient of uniformly high standard, available at all times by a staff of nurses prepared to render part time home service.

It offers the patient interested, intelligent, efficient nursing service at a cost made reasonable because the nurse is able to use her time to equal advantage whether she is making a regular visit or answering an hourly call.

Vital Statistics *

By T. F. Murphy, M.D.
Chief Statistician for Vital Statistics, Bureau of the Census, Washington

IT is most encouraging to those of us who are engaged in this work to realize that such organizations as yours are interested in the subject of Vital Statistics. I feel that some parts of this subject are very close to your own hearts and that you are greatly interested in others in view of the vocation you have chosen.

There is some difference of opinion as to the true definition of vital statistics but in its broadest sense it includes the whole study of man so far as the results of this study can be arithmetically stated. Generally speaking, however, it deals with births, marriages, divorces and deaths. The purpose of vital statistics, like that of any statistics, is both scientific and utilitarian. Under the first heading comes ascertaining and classifying facts and preparing the way for investigation of causes and under the second studying evil conditions and their sources with a view to their removal. In dealing with vital statistics, it should be borne in mind that it is not possible intelligently to study one issue at a time. In other words, when birth registration is being studied consideration must be given to the characteristics of the population, economic conditions, sex, race, and other social phenomena. In the natural order of things, I suppose I should begin my talk by discussing births, but first I wish to say a few words on the entire subject.

THE REGISTRATION AREA

The Federal Government has established a so-called registration area for births and deaths. To become part of this area, it is necessary for a state or city to register under adequate state laws or municipal ordinances at least 90 per cent of all births and of all deaths. At the present time, the death registration area is composed of 46 states, nine cities in non-registration states, the District of Columbia, Hawaii, and the Virgin Islands. This area comprises approximately 96 per cent of the total population of the United States. The only states outside the registration area are South Dakota and Texas, and both of them have requested the Federal Government to test the efficiency of their registration. The birth registration area contains 46 states and the District of Columbia, the Virgin Islands and approximately 95 per cent of the total population. In other words, it is the same as the death registration area, with the exception of several cities in the former which are not included in the latter.

BIRTH REGISTRATION

It is a well-known fact that for a number of years the birth rate in this country, and, in fact, in practically all countries, has been steadily decreasing. This is due to a number of factors, among which are the restriction of immigration; the migration of young people from rural to urban areas, where they often enter industrial pursuits; economic factors, etc. As late as the year 1920 the birth rate per 1,000 population was 23.7 and in the year 1928 it was 19.7. Estimates made for the year 1929 indicate that there will be a still further decrease. The subject of birth rates and birth registration, therefore, is one in which we are greatly interested. In France, according to a newspaper dispatch, the number of births over deaths for last year was only 12,564, as compared with 70,000, which was the seven-year average.

In 1915 the Federal Government established a birth registration area which numbered only 10 states and in-

* Address before the general session of the National Organization for Public Health Nursing, Biennial Convention, Milwaukee, Wis., June 10, 1930.

cluded less than one-third of the population. There are now 46 states and the District of Columbia, or a total of 95.4 per cent of the total population of the United States. To those who for years have been advocating the registration of births, it seems incomprehensible that there should be any but the heartiest coöperation in each and every state on this subject. I personally believe that the failure of parents to have the births of their children registered is due to ignorance of the subject. There is hardly a relation of life, social, legal, or economic, in which the evidence furnished by accurate registration of births may not prove to be of the greatest value, not only to the individual, but also to the public at large. It is not only an act of civilization to register births but good business, for the certificates are frequently used in many practical ways. From those who have given some thought to the subject, may I list a few of the values of a birth certificate:

As evidence to prove the age and legitimacy of heirs;
As proof of age to determine the validity of a contract entered into by an alleged minor;
As evidence to establish age and proof of citizenship and descent in order to vote;
As evidence to establish the right of admission to the professions and to many public offices;
As evidence of legal age to marry;
As evidence to prove the claims of widows and orphans under the widows' and orphans' pension law;
As evidence to determine the liability of parents for the debts of a minor;
As evidence in the administration of estates, the settlement of insurance and pensions;
As evidence to prove the irresponsibility of children under legal age for crime and misdemeanor, and various other matters in the criminal code;
As evidence in the enforcement of law relating to education and to child labor;
As evidence to determine the relations of guardians and wards;
As proof of citizenship in order to obtain a passport;
As evidence in the claim for exemption from or the right to jury and military service.

If only one of the values listed above could be secured by the registration of a child, I believe it would be sufficient reason to do so, but when not only one but all of them are served by the registration of the birth, there can be no valid reason for not doing so.

As I said before, I believe that the only reason that we do not have 100 per cent registration in every state in the Union is due to lack of knowledge of the subject. There is scarcely a day passes but what the Federal Bureau has requests for certificates of birth, and from information I have received from the different states the daily requests for the United States as a whole must amount to hundreds. It has been an especial boon to those engaged in the World War, as the birth certificate determined the age and proof of citizenship and as an evidence for compensation under the various acts of the Veterans' Bureau. For evidence in legal affairs, it is beyond measure. In fact, a certificate of birth issued by a state serves to answer at any time the question "Who am I?"

EXAMPLES OF THE VALUE OF BIRTH CERTIFICATES

The following illustrations will serve to emphasize the value of birth certificates:

"A man in a Southern state died, leaving his widow a piece of property which was not considered to be valuable. Some months after the husband's death a child was born. After a while the property was sold for taxes. Some years later, a corporation desired to purchase the property, which is now worth a fortune. The investigation of titles showed a child had the right of redemption if it could be shown that said child was the legitimate offspring of the former owner. The date of the death of the man was known. The date of the birth of the child had to be proven. A search of the records of the county health officer showed that the doctor had failed to report the birth. The doctor was dead. The mother could find no one by whom to prove the date of her child's birth. Hence, the child was branded as an illegitimate and lost a fortune of $50,000, all because the doctor failed to do his duty."

An Associated Press dispatch from a Northern state, January 4, reads as follows:

"Mr. George A. Blank of this city has struck a peculiar obstacle in the preliminaries necessary to his taking the office of

probate judge, to which he was recently elected. He can not find any record of his birth, and the law requires that a certificate of birth must be filed with the secretary of state before a judge can be commissioned.

"Mr. Blank has always been led to believe that he was born in Manchester, May 28, 1873. His parents told him and he has seen it so stated in print many times, but when he called at the office of the city clerk he was told that there was no record of his birth on file there."

These illustrations could be multiplied many times, especially during the World War when so many residents with foreign names had great difficulty in proving their citizenship. You will see, therefore, what responsibility is placed on public health nurses in starting children on the right road through life as well as in protecting the mothers of these children by teaching them the simple methods of taking care of their health and also caring for their children.

MARRIAGE AND DIVORCE

Since 1922, statistics of marriage and divorce have been collected annually. Prior to that time, the Bureau of the Census issued two reports on these subjects, the first covering a twenty-year period from 1887 to 1906, and the second for the single year 1916. It had been the intention to have this latter report cover the ten-year period from 1907 to 1916, but conditions brought about by the World War prevented. In 1926 the investigation was extended to include marriages which were annulled because of the close relationship existing between the annulment-marriage and the dissolution of marriage by divorce. The marriage returns are furnished from state records through the State Boards of Health or Public Welfare Departments in a majority of the states, and for the remainder, the information is obtained through correspondence with court officials.

The Federal Government is unable to publish detailed statistics on marriage and divorce due to the fact that in no two states are marriage and divorce laws exactly alike. In one state, persons of very young ages may marry. According to a report made by the Russell Sage Foundation, in some states girls may marry as early as 12 years of age. Many counties of the states do not require other than the names of the contracting parties, and the fact that they appear to be of legal age. For this reason, it has been deemed impracticable to attempt to collect uniform statistics of age, color, nativity, previous marital condition, etc. Likewise, the law of one state will permit divorces for very simple reasons or almost no reason at all, while in others only the extreme cause will separate married persons. The Commission on Uniform State Laws has been endeavoring for many years to obtain uniform marriage laws, and in recent years a model bill relating to marriage and divorce has been urged by this Commission.

It is not my purpose to worry you with a lot of figures, but as an evidence of the increased number of divorces, may I say that in 1922 there were 148,815 divorces granted, and in 1928 there were 195,939, an increase of 47,124, or over 31 per cent in six years. Or to put it another way, the number of divorces granted in the United States increased from one divorce to every 17 marriages in 1887 to one divorce to every six marriages in 1928, the increase being much more rapid during the 10 years from 1919 to 1928 than in the earlier part of the forty-year period covered by the statistics.

It is significant that of the total number of divorces granted in 1928, 56.6 reported no children; children were reported in approximately 37 per cent. Of the divorces granted to the husband, 64 per cent reported no children, and of divorces granted to the wife 54 per cent reported no children. It is rather distressing, however, to know that for the United States as a whole there were 126,578 children affected by the divorces granted during the year 1928. In addition to the number of divorces, there were 4,237 marriages annulled. These annulments were due to three principal reasons,

bigamy, under legal age, and fraudulent representation. It is quite reasonable to presume that the 1,119 annulments made because one or both of the parties were under legal age and quite possibly a number of the annulments secured under the heading "Fraudulent Representation" would be avoided provided a birth certificate were required when an application is made for a marriage license. I mention these statistics because they have an intimate bearing on the subject of birth registration.

DEATH REGISTRATION

The mortality statistics compiled by this Bureau furnish a collection of data which are invaluable to the medical profession, insurance statisticians, group insurance organizations, health officers, sanitarians, social workers, and to a large number of others who use the data for scientific or utilitarian purposes.

The Bureau has been trying for a number of years to educate physicians and others to adopt a definite nomenclature, not merely sequelæ or terminal symptoms, when certifying the cause of death, so that the statistics, when published, may be accurate and comparable. You may be interested to hear some of the causes by which one could leave this vale of tears, as reported on our returns. A number of years ago, such terms as "not born right," "rising in head," "born and dies," "visitation of God," etc., once very popular, have now lost favor. To show that it could be done, some of the certificates gave as the cause of death, "Died without the aid of a doctor."

Since 1900 there has been a marked improvement in the certification of causes of death. The number of returns similar to those noted above is growing less to the great satisfaction of all those interested in mortality statistics. While there is a certain justification for indefinite terms when the cause of death is given by a member of a family or a midwife, the same excuse can not be accepted when the certificates are filed by those with some knowledge of medicine.

For the year 1927, the Bureau queried approximately 37,000 certificates and as a result of the additional information received from 22,400 replies there were approximately 10,000 changes made in the assignments, or about 44 per cent. I might cite a few examples:

We know full well that bronchial pneumonia is a very common sequela of the infectious diseases, especially in children, and this disease is often given as the cause of death instead of the infectious disease. Septicemia, sepsis and blood poisoning are other terms which require explanation. A septicemia from a puerperal condition is one thing; a septicemia following violence is entirely another. We are perfectly willing to admit that hemorrhage can cause death, but we also insist on knowing what caused the hemorrhage.

Let me give you a concrete illustration of what will develop as a result of persistent querying on our part:

A short time ago a certificate was received on which the cause of death was given as "burns." Now if a burn is received as the result of a conflagration, it has a definite number in our code, but if the burn results from clothing becoming ignited or falling into an open fire, that is an entirely different thing. So we wrote the doctor and asked him to advise us how the "burns" were received. His reply was that they were X-ray burns. This certainly changed the complexion of the certificate entirely, and we again wrote him asking for what purpose the X-ray was used. His reply this time stated that the woman had been a sufferer from cancer of the breast for many years and she was brought to his office for treatment.

THE NURSE'S RESPONSIBILITY

Among the duties, as I see them, of the public health nurse is the complete filling out of a birth or death certificate when a birth or death occurs in their service. As many of you take the places of doctors in sparsely settled districts, you are probably familiar with the International List of Causes of Death. A Physicians' Pocket Reference based on this list has been issued, and a new one based on the revision of the 1930 list will be issued during the present year. You, of course, know what undesirable terms are in the present Pocket Reference and you realize the importance of giving defi-

nite and complete information concerning births or causes of death.

A part of the new death certificate, and also the birth certificate, which is important is the section dealing with occupation, as from complete statements of occupations we will be permitted to compile not only mortality statistics by occupation, but "occupational mortality" statistics. Some people have raised the question of the inclusion of occupations on the certificates of birth, but if we are to study, as public health nurses and other health workers often wish to do, the social and economic conditions of a community and especially infant mortality and maternal mortality, occupations of mothers are a very important factor. Accordingly, these items have been included on the birth certificate identical with the items on the death certificate and on both certificates are in conformity with the population schedule, so that from population records we should be able to check up occupations of parents and decedents at least for an interval of one to three years. We will soon issue a very important Pocket Reference dealing with the reporting of occupations on birth certificates.

In order to do her work in the most intelligent manner, it is quite necessary that the public health nurse should be familiar with the constituent elements of the population which make up her county or other area under her jurisdiction. For that purpose, therefore, she should be familiar with the returns published by the population division of the Bureau of the Census. To do her work most effectively she should know the ratio of each sex in each county, the race, color, and roughly, the age groups. To these she should apply the birth and mortality returns for the same year. All of these factors will be of great assistance to her in carrying out her work in a more intelligent manner. In fact, in my opinion, the nurse can not render most effective work without having a knowledge of the factors I have mentioned.

Public health nurses may feel that vital statistics are of a cut and dried nature, but when they realize the importance of figures as indexes of health in communities our compilations of birth and mortality data will prove of inestimable value to them and enable them to discharge more completely their duties to the county, state, and medical profession.

NATIONAL TUBERCULOSIS CONVENTION

The 26th annual meeting of the National Tuberculosis Association was held in Memphis May 7–10. A number of interesting features were offered in the program for this year's meeting.

Various features of pulmonary diagnosis and the indications for and technique of operations in surgery of the chest, particularly of the phrenic nerve, were presented by physicians chosen especially because of their intimate knowledge of the subject. A paper on the crystallization of our knowledge of childhood tuberculosis was presented by Dr. J. A. Myers.

The principal topic in the Pathological Section was the consideration of the carbohydrates of the tubercle bacillus.

The Sociological Section covered the epidemiological and sociological aspects of tuberculosis among negroes, the report of a study dealing with measurements of results of tuberculosis programs in a generalized nursing service, and child health education from the point of view of the place of non-official agencies in relation to school authorities.

The Administrative Section made a radical departure from the usual set procedure for programs of this character. The first session was a critique on printed matter for health education. The second session consisted of a demonstration of the Alabama Movable School, a unique institution both in its set-up and in its methods. It is manned entirely by a staff of colored workers and operates under the general auspices of Tuskegee Institute.

The Sixth Annual Conference on Child Health Education for Tuberculosis Workers was held on Saturday afternoon, May 10. Particular emphasis was laid on health work in High Schools and the use of the teacher's inventory of health assets in rural and city schools.

Violet H. Hodgson

Sanitary Engineering *

By F. Gardner Legg
Sanitary Engineer, City Department of Health, Detroit, Mich.

THE public health worker, no matter in what branch of the service he or she may be employed is, as the term implies, a public servant, and as such dependent upon public opinion for support or condemnation as the case may be. With all its disadvantages there is a fascinating satisfaction in public work that enables one to soon forget most of the unpleasant things and to visualize an unlimited field of opportunity for service to others, which after all is the one thing in life that is really worthwhile.

IN THE EYES OF THE PUBLIC

Believing we have a place in the general order of activities and assuming that we are really enthusiastic about our work, just what are we going to do about it? Shall we assume an attitude of silent plodding, hoping that the public will eventually realize the benefit derived from our efforts and respect us accordingly, or shall we shout our accomplishments from the housetops? The quiet retiring worker is usually respected by his immediate associates, yet his reputation seldom extends beyond the boundaries of his department; on the other hand, the know-it-all, blustering type of individual often flourishes as a hothouse plant and waxes great and forceful under the warmth of his surroundings. Place him alone in the chilling blasts of adversity and he is likely to be susceptible to the ever menacing frosts of skepticism. It is our duty to the public, to our superiors, and to ourselves, to increase our general knowledge of as many phases of public health activities as possible in order that we may merit respect and confidence. With this accomplishment, then and only then can we qualify as respected advocates of and leaders in public health activities.

Health Departments theoretically are constituted for the sole purpose of suppressing the spread of infectious and contagious diseases, and for the enforcement of laws intended for the conservation of health. The Health Officer may with the backing of the courts wield a scepter of power and authority excelled by no other constituted official. The exercise of this police power in modern administrative practice is, however, the exception rather than the rule. Today, the educational activities of the department are considered the most important functions and the public health nurse is in reality the salesman for worthwhile beneficial programs. As, in industry, the successful salesman enables the manufacturer to approach mass production, so in public health work, the nurse and the other field workers are the dispensers of that greatest of assets to the success of any organization, namely, "Good Will."

The field workers, whether doctor, nurse, inspector, or service clerks in every department, can make or break any health organization. So much depends upon the impressions gained by the public in daily contact with these persons that personality and general knowledge of public health regulations and activities is of such importance that no department can afford to permit a disinterested and incompetent employee to serve in such capacities.

A SOURCE OF INFORMATION AND HELP

The public health nurse, from the very nature of her work, is thrown into intimate contact with the social structure of modern times. Because of the prestige of her position and the educational possibilities presented in her home contacts, it is my belief that public health nurses can and will do more constructive health work than any

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other organized group. It is my feeling, however, that it may be necessary to introduce some social service work along with health programs in many localities. The school child is taught through intelligent and tactful methods to respect the advice of the teacher. He is encouraged to cultivate a spirit of admiration for the traffic police and a feeling of security in his presence rather than fear at the sight of his uniform, his club, or conspicuous revolver. If our modern methods of health education are to succeed, the grown-ups, the fathers and the mothers, must, in a similar manner, be brought to a realization that the health worker is not to be looked upon with fear and trembling, as a dispenser of monotonous quarantines, a suggester of painful operations, or a server of court summonses, but rather a friend in need, ready and willing to listen sympathetically to troubles and afflictions, and so trained as to be able to answer definitely the questions that so often perplex and worry the individual.

It is my aim to arouse your interest in various engineering activities by indicating their close relationship to public health services and to create in you a desire to stimulate your knowledge of the subject as opportunity may afford.

QUESTIONS OF ENVIRONMENT

In many respects we are living in an era of indifference. Progress is seemingly so rapid that the perfections of today become the antiques of tomorrow. Modern conveniences we accept as a matter of course, giving little thought to the fundamental principles of their operation. Our comprehensive water supply systems, sanitary appliances, complicated house plumbing and garbage and refuse collection and disposal methods, refrigerating systems, various types of building operations are all associated with technical engineering activities and in the larger communities are in a measure correlated with public health functions. The sanitation of swimming pools is the responsibility of the sanitary engineer. Industrial nuisances such as noises, odors, smoke and dust abatement programs, mosquito control, street cleaning, rat extermination, and the supervision of commercial fumigation are likewise problems for the trained sanitarian.

A water supply of unquestionable purity is of first importance for the health of any home, or organized community. Whether this supply may be obtained from wells or whether it is necessary to resort to natural bodies of water such as lakes and streams depends upon such factors as the geological formations of the locality and the volume of the demand. Generally speaking, the amount that may be obtained from wells or springs is of too limited volume to enable our larger cities to develop these methods of supply. Naturally this forces them to such sources as inland lakes and rivers. As the pollution of these surface sources is constantly increasing, mechanical methods of purification must be relied upon to insure a potable water at the drinking tap. Wells are not always dependable, as experience has demonstrated that soil pollution very often influences their purity, and seepage from privy vaults, cesspools and leaking sewers has caused many cases of typhoid even in our rural districts. The supervision of all water supplies should be so assigned to competent authorities that the chances of contamination will be reduced to an absolute minimum.

There are many possibilities for the contamination of local water distribution systems that have developed in recent years—such as industrial cross connections in which polluted water may be forced into the city mains, and improperly designed plumbing fixtures, wherein it is possible, under certain conditions to syphon the contents of the fixture directly into the drinking supply lines. The alert sanitary engineer is very active in devising ways and means of eliminating these hazards and in some cases a complete change in present practices will be required.

Modern methods of general water distribution under pressure have made

possible the conveniences of plumbing and this in itself has further complicated the sanitary problems of the community. The "Used Water" which for all practical purposes may be considered as sewage, must be properly conducted from the home and from the community and disposed of in such a manner that it will not become a menace to any source of water supply or a nuisance along its line of travel or at the location of the treatment works.

The science of sewage treatment is advancing from year to year, but I believe it can be safely stated without fear of contradiction that the ultimate solution of all sewage disposal problems is still an event to be hopefully anticipated. The same is true with respect to garbage and refuse collection and disposal methods. At the present time no one particular system can be recommended as the best for all conditions, as each community is a problem by itself and must be considered as such by all who would attempt to advise local officials on these particular problems.

CONFUSED INFORMATION

The fundamental principles of sanitation are the same the world over, the degree of elaboration, however, may vary with the circumstances. It surely is of no credit to the profession to have permitted the public to become so erroneously misled in many of the fundamental principles of water supply and sewage disposal methods. It is the general impression that a few feet of sand or gravel is sufficient to purify the vilest of liquid wastes, that under any conditions a running stream, in the course of a mile, will purify itself, and that the septic tank is the "Alpha and Omega" of all sewage disposal problems. These ideas will continue to prevail until those responsible for sanitary installations are willing to understand or to acknowledge their limitations.

Laws and regulations supposedly based upon sanitary principles are lacking in uniformity with the result that there is considerable confusion in the public mind as to the necessity for many of our so-called sanitary regulations. Many laws and ordinances, enacted under the guise of legislation necessary for the preservation of public health, have no relationship whatsoever to those conditions universally recognized as affecting health.

The problems in the urban community are quite different from those in the strictly rural districts, and no general rule of guidance can be proposed with certainty. As a community develops in size the problems of general sanitation are multiplied in proportion. The rural dweller may resort to many practices that must necessarily be restricted in any urban locality. The barn and barnyard, the pig pen, and hen house with attending fowl and animal life and litter resulting therefrom are necessary to agricultural pursuits. Whatever nuisances arise from these necessities must be endured by the farmer and his family. His neighbor maintains similar conditions on his property, but the distances between are usually such that neither condition creates any cause for public concern.

NEED OF STANDARDIZED REGULATIONS

The urban dweller must, on account of his surroundings, take into consideration the rights and privileges of his neighbors, and so maintain his premises that others will have no cause to feel that, by his conduct or practices, they are being hindered in the enjoyment of their property. Various laws and ordinances are necessary as guides for social conduct. If we all knew what to do and how to do those things essential for the maintenance of sanitary conditions in a community, and would apply this knowledge, there would be no need for sanitary inspectors. Until the time approaches that our fundamental regulations become so standardized as to be easily understood and methods made uniform, we will be forced to rely upon the field worker, acting as an instructor where possible and as an officer of the law where necessary, to guide the citizen into the paths of common decency.

Efforts to cultivate a spirit of civic

pride in the larger municipalities with their complex cosmopolitan populations are often discouraging. There is so much laxity due to ignorance and indifference that the more intelligent and coöperative individual not only becomes dissatisfied with his surroundings, but often loses interest in his attempt to abide by sanitary regulations when chaotic conditions prevail on every hand. Some contend that strict law enforcement is the one and only solution. This method is generally advocated by those inexperienced in our cumbersome court procedures. It is nice to anticipate, but difficult to realize. Educational methods are also slow and limited in scope on account of lack of personnel. However, with the coöperation of civic organizations and volunteer agencies, we are gradually reaching larger groups with the result that the public is more coöperative today than in the past. When one is convinced of the necessity and reason for health conservation measures the chances are one will also become an advocate of those principles that foster healthier and happier communities.

PROPER HOUSING

Proper and adequate housing is becoming one of our greatest social problems. The relative proportion of private or single home owners is decreasing at an alarming rate. This indicates that there is a growing tendency to crowd into apartments resulting generally in intensifying the occupancy of both buildings and land.

Light and air are necessary for the healthful maintenance of occupied spaces. Dismal, damp and poorly ventilated dwellings contribute to disease and often crime, and foster a spirit of disrespect for law and decency.

Complications arising from the lack of understanding as to the responsibility of both owner and tenant are additional disadvantages to these modern housing methods. The number of complaints to health departments originating from such misunderstandings is considerable.

TAKE TIME TO GIVE INFORMATION

In twenty years of public service, it has been my experience that people are generally anxious to coöperate with all reasonable requests, but sometimes they wish to be convinced of the necessity for these demands. Rather than lose patience with these persons and incur their ill will thereby, it pays to go out of one's way to give that person all the information possible. When any one questions the necessity for this law or that regulation or some certain action, it is my belief that such individual is not an obstructionist in any sense of the term, but is only seeking authoritative information upon matters concerning which he has but limited knowledge. The ability to so answer his questions that no doubt will remain in his mind as to the reasonableness of the demand or request is the secret of progressive public service. You have thereby not only thoroughly accomplished your duty as an official, but, what is more, you have surely planted a seed of respect for your profession and your department that will sooner or later bear fruit. Let us endeavor to become walking encyclopedias for the general dissemination of such information as will encourage a healthier and happier existence for all mankind.

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